

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 9, Film G241, 4/15/59 fcy
3940
CERTIFICATE OF DEATH

03914
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b Baltimore 9 3001-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 5718 Pimlico Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle John Last Adelhardt		4. DATE OF DEATH Month 4 Day 2 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1889 89 yrs.
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Sears, Roebuck	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Adelhardt		14. MOTHER'S MAIDEN NAME Louise Kemper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. 217-03-4782	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Thrombosis of Carotid Artery DUE TO (b) General Arteriosclerosis DUE TO (c) 4-5 years		INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/19, 1958 to 4/2, 1959 , that I last saw the deceased alive on 4/2, 1959 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE W. Newcomer		M.D. Superintendent	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4, 1959	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Byers		ADDRESS 8728 Liberty Rd. Randalltown, Md.	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. King	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>	
<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>	
<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>	
<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>	
<p>10. Signature of registrar: <u>[Signature]</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03915

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Court Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BRYSON RIDGLEY ALBAUGH</u>		4. DATE OF DEATH <u>Apr 1 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Salesman and Venetian Blind</u>	
11. BIRTH PLACE (State or foreign country) <u>Balto City.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Albough Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Alice Murray Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-03-5580</u>	
17. INFORMANT <u>John F. Albough Jr.</u>		Address <u>Old Court Rd. Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>690.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbuncle of neck</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>2 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>none</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		DATE SIGNED <u>4-1-59</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto.</u>		24a. REC'D BY REGISTRAR <u>APR 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

FOR STATE
DEATH CERTIFICATE

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Manner of death
6. Signature of physician
7. Signature of medical examiner
8. Signature of coroner
9. Signature of registrar
10. Signature of clerk

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF MEDICAL EXAMINER

SIGNATURE OF CORONER

SIGNATURE OF REGISTRAR

SIGNATURE OF CLERK

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1 4 M 014 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death. 3942 03916 Reg. Dist. No. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr7mth2ldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First Mae Middle Carrie Last Allport		4. DATE OF DEATH Month 4 Day 6 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 65 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac insufficiency DUE TO Arteriosclerotic cardiovascular dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized Arteriosclerosis DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6, 1959 , to 4-6-1959 , that I last saw the deceased alive on 4-6-1959 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-7-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF April 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

504-61

3943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roper Forge</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Dunbarton Rd</u>				d. STREET ADDRESS <u>105 Dunbarton Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>C.</u> Last <u>Austin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1892</u>	
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto MD</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Austin</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Koch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wife</u>		Address <u>105 Dunbarton Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>ONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 16</u> , 19 <u>46</u> , to <u>Apr 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 10</u> , 19 <u>59</u> , and that death occurred at <u>7:10</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.S. Chalfant</u> M.D.				ADDRESS (Street, city or town, state) <u>6310 YORK ROAD</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u>				BALTIMORE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Scumum</u> ADDRESS <u>6067 Hay Rd</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3944

CERTIFICATE OF DEATH

03918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. STREET ADDRESS 1615 S. Marshall St.			
3. NAME OF DECEASED (Type or print) Anna First Bailey Last				4. DATE OF DEATH April Month 19 Day 59 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 14, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) United States				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Charles Sipes				14. MOTHER'S MAIDEN NAME Mamie Addams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1958 , to April 19, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 10:15AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-19-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				James Donald Brinkard, M.D. Catonsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-59		22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. JONES</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3945

CERTIFICATE OF DEATH

03919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 84 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle E Last BALIS, SR		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Luray, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Balis		14. MOTHER'S MAIDEN NAME Cora Berkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 196-10-0910	
17. INFORMANT Clin. Recs., Vet. Adm. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS WITH METASTASES, 1992 XXXX PRIMARY SITE UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 8 , 19 59 , to April 2 , 19 59 , and that death occurred at 6:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FT. HOWARD, MD 4/2/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH FT. HOWARD, MD	
PHYSICIAN'S NAME (Type) JOHN W CRAWFORD, M.D.		VAH Ft. Howard, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips		ADDRESS 1802 N Monroe St Balto Md	
24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

3222

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1900		New York City	
Occupation		Cause of Death		Date of Death		Place of Death		Manner of Death	
Teacher		Heart Disease		Jan 10, 1945		Home		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Signature of Reporter		Signature of Reviewer	
Jan 12, 1945		10:00 AM		Baltimore, MD		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3946

CERTIFICATE OF DEATH

03920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 BERRYMAN'S LANE</u>		d. STREET ADDRESS <u>18 BERRYMAN'S LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADRIAN W. BALL</u>		4. DATE OF DEATH Month Day Year <u>APRIL 1 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BRICKLAYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HERBERT W. BALL - 18 BERRYMAN'S LANE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decompensation</u> <u>as in chronic general</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-10-59</u> 19 <u>59</u> , to <u>4-1-59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3-28-59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James G. Siffell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown, Md 4-1-59</u>	
PHYSICIAN'S NAME (Type) <u>James G. Siffell</u>		ADDRESS <u>Reisterstown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLETOWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Donovan - 3818 Poland Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Donovan</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>		c. LENGTH OF STAY IN 1b <u>51</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1941 Belle Ave</u>				d. STREET ADDRESS <u>1941 Belle Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Baranay</u> Last <u></u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 2 1887</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Paper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Bulgaria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Baranay</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Eli</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Katherine Baranay</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease</u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>April 22 59</u>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H Hubbard</u>				ADDRESS <u>4101 Wilkens Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8232 Kavanaugh Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alma Middle E. Last Bare		4. DATE OF DEATH Month April Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kentucky	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram Jones		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Leona Smith 8232 Kavanaugh Rd. 22	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis of Heart Arteries 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack C Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack C Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-59	22c. NAME OF CEMETERY OR CREMATORY Maysville Cemetery
		22d. LOCATION (City, town, or county) (State) Maysville, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 241 4-30-59 ams

3947

CERTIFICATE OF DEATH

Reg. Dist. No.

03923

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 5 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First HERMAN Middle A. Last BAUMGARTNER			4. DATE OF DEATH Month April Day 24 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1899		9. AGE (In years last birthday) yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman			10b. KIND OF BUSINESS OR INDUSTRY Protective Assn.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Michael Baumgartner		
14. MOTHER'S MAIDEN NAME Louise Kilgus			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. 218-12-3351			17. INFORMANT Clin. Records, VAH Ft. Howard, Md.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG, LEFT 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		

21. I certify that VA attended the deceased from April 19, 1959 , to April 24, 1959 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED 4/25/59					
ACTUAL SIGNATURE Roland D. Ponce de Leon M.D. VA Hospital, Ft. Howard, Md. 4/25/59					
PHYSICIAN'S NAME (Type) ROLAND D. PONCE DE LEON, M.D. VA Hospital, Ft. Howard, Md. 4/25/59					

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cemetery	22d. LOCATION (City, town, or county) (State) Kenwood & Belair Rd., Balto., Md.
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23. FUNERAL DIRECTOR'S SIGNATURE James J. Bruzdinski	ADDRESS 1407 Eastern Ave., Balto., Md.	24a. REC'D BY REGISTRAR DATE APR 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3441

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 03924											
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville, Md</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Nursing Home</u>						d. STREET ADDRESS <u>formerly of The Marylander Apts.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Katherine F Becker</u>						4. DATE OF DEATH Month Day Year <u>April 27 1959</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1, 1876</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>5 mo 27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>			
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME <u>George Frankie</u>						14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>Hospital Records</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis & arteriosclerotic heart disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>58</u> , to <u>Present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>59</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Ernest C Brown Jr.</u>						ADDRESS (Street, city or town, state) <u>1101 N. Calvert St Balt. 2</u>					
PHYSICIAN'S NAME (Type) <u>ERNEST C. BROWN JR</u>						DATE <u>4/28/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/29/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>			
				22d. LOCATION (City, town, or county) (State) <u>Pikerville, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt. Md</u>						24. REG'D BY REGISTRAR DATE <u>APR 28 59</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG241 4-20-59 et

CERTIFICATE OF DEATH

3949

03925
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rodgers Forge</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>				d. STREET ADDRESS <i>2606 Wentworth Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Frank M. Beierli</i>				4. DATE OF DEATH Month Day Year <i>April 9th 19 59</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 10, 1886</i>	9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Yugoslavia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>213-09-5484</i>		17. INFORMANT Address <i>Mrs. Magdalena Beierli, same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>pneumonia</i> DUE TO (c) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>generalized and cerebral arteriosclerosis. Old cerebro-vascular accident.</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>12-27-58</i> , 19 <i>58</i> , to <i>4-9-59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4-8-59</i> , 19 <i>59</i> , and that death occurred at <i>7:10 a.m.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Frank J. Ayd, Jr.</i> M.D. <i>6231 York Road, Baltimore 12, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/13/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				24a. REC'D BY REGISTRAR DATE <i>APR 13 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03926

3950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Baltimore (28)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave.				d. STREET ADDRESS Formerly of 6 Overbrook Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louisa M. Berger				4. DATE OF DEATH Month Day Year April 11/59 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1878	9. AGE (In years lost birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonhard Lehr				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address John H. Berger, 6311 Mt. Ridge Rd. Catonsville 28.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral Thrombosis DUE TO (c) Cerebral Thrombosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seizure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 50 , to April 11 , 19 59 , that I last saw the deceased alive on April 10 , 19 59 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. C. MacLaughlin		M.D. 4508 Edmondson Village		ADDRESS (Street, city or town/state) 4508 Edmondson Village, Balto. 29, Md.		DATE SIGNED 4/13/59	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D., 4508 Edmondson Village, Balto. 29, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 14/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors				ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE APR 14 59	
				24b. REGISTRAR'S SIGNATURE Richard L. Bennett			

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Baltimore

Celebration

House in 1911, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3951

CERTIFICATE OF DEATH

03927
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>	c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Repp Nursing Home</u>		d. STREET ADDRESS <u>814 Templecliff Pl. #8</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>E.</u> Last <u>Betts</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Hudgins</u>		14. MOTHER'S MAIDEN NAME <u>S. Rebecca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Robert Hunter</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis, chronic</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>58</u> , to <u>April 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 2 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Jenkins</u> ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3051

3051

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES M. JONES		Male		35		White		1968		At Home	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM	
None		Heart Disease		Natural		Hypertension		Myocardial Infarction		None	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased.

3. The manner of death should be stated as either natural, accidental, or homicidal.

4. The medical history should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased.

5. The present illness should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased.

6. The post-mortem should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased.

7. The signature of the physician or other qualified person who has attended the deceased during his or her illness or who has attended the deceased at the time of death is required.

8. The signature of the registrar is required.

9. The signature of the witness is required.

10. The signature of the deceased is required.

11. The signature of the next of kin is required.

12. The signature of the clerk is required.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3952 CERTIFICATE OF DEATH

03928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. 19.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>As</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks Pt.</i>				c. LENGTH OF STAY IN 1b <i>32 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3107 Greenhill Ave</i>				d. STREET ADDRESS <i># 1.</i>			
3. NAME OF DECEASED (Type or print) <i>VINCENTY. WM. BIELAWSKI</i>				4. DATE OF DEATH <i>April 15 1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 25 1884</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel mill</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Vincenty Bielawski</i>				14. MOTHER'S MAIDEN NAME <i>Mary Anna Lizarowicz</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>213072863</i>		17. INFORMANT <i>Anna Bielawski</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Failure</i> <i>241X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchial asthma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>11 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1950</i> , to <i>April 15 1959</i> , that I last saw the deceased alive on <i>April 14 1959</i> , and that death occurred at <i>7:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis N. Tollin</i> M.D.				ADDRESS (Street, City or town, state) <i>6908 N. Ft. Rd. Balto 19 Md</i> DATE SIGNED <i>4/15/59</i>			
PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/18/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>SACRED Heart of MARY GERMAN HILL Rd</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George A Weber</i> ADDRESS <i>705 S Ann st</i>				24a. REC'D BY REGISTRAR <i>DATE APR 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles E. K...</i>	

CERTIFICATE OF DEATH

3385

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES EARL RAY		Male		35		10-10-38		10-10-68		St. Louis, Mo.		Suicide		Suicide		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Date of marriage		15. Date of divorce		16. Date of remarriage		17. Date of death		18. Date of burial		19. Date of interment		20. Date of cremation	
Attorney		High School		Married		1960						10-10-68		10-10-68		10-10-68		10-10-68	
21. Name of informant		22. Address of informant		23. Telephone number		24. Date of interview		25. Date of death		26. Date of burial		27. Date of interment		28. Date of cremation		29. Date of death		30. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
31. Name of informant		32. Address of informant		33. Telephone number		34. Date of interview		35. Date of death		36. Date of burial		37. Date of interment		38. Date of cremation		39. Date of death		40. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
39. Name of informant		40. Address of informant		41. Telephone number		42. Date of interview		43. Date of death		44. Date of burial		45. Date of interment		46. Date of cremation		47. Date of death		48. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
49. Name of informant		50. Address of informant		51. Telephone number		52. Date of interview		53. Date of death		54. Date of burial		55. Date of interment		56. Date of cremation		57. Date of death		58. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
59. Name of informant		60. Address of informant		61. Telephone number		62. Date of interview		63. Date of death		64. Date of burial		65. Date of interment		66. Date of cremation		67. Date of death		68. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
69. Name of informant		70. Address of informant		71. Telephone number		72. Date of interview		73. Date of death		74. Date of burial		75. Date of interment		76. Date of cremation		77. Date of death		78. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
79. Name of informant		80. Address of informant		81. Telephone number		82. Date of interview		83. Date of death		84. Date of burial		85. Date of interment		86. Date of cremation		87. Date of death		88. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
89. Name of informant		90. Address of informant		91. Telephone number		92. Date of interview		93. Date of death		94. Date of burial		95. Date of interment		96. Date of cremation		97. Date of death		98. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	
99. Name of informant		100. Address of informant		101. Telephone number		102. Date of interview		103. Date of death		104. Date of burial		105. Date of interment		106. Date of cremation		107. Date of death		108. Date of burial	
[Signature]		[Address]		[Phone]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]		[Date]	

1. Name of informant
2. Address of informant
3. Telephone number
4. Date of interview
5. Date of death
6. Date of burial
7. Date of interment
8. Date of cremation
9. Date of death
10. Date of burial
11. Date of interment
12. Date of cremation
13. Date of death
14. Date of burial
15. Date of interment
16. Date of cremation
17. Date of death
18. Date of burial
19. Date of interment
20. Date of cremation
21. Date of death
22. Date of burial
23. Date of interment
24. Date of cremation
25. Date of death
26. Date of burial
27. Date of interment
28. Date of cremation
29. Date of death
30. Date of burial
31. Date of interment
32. Date of cremation
33. Date of death
34. Date of burial
35. Date of interment
36. Date of cremation
37. Date of death
38. Date of burial
39. Date of interment
40. Date of cremation
41. Date of death
42. Date of burial
43. Date of interment
44. Date of cremation
45. Date of death
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47. Date of interment
48. Date of cremation
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74. Date of burial
75. Date of interment
76. Date of cremation
77. Date of death
78. Date of burial
79. Date of interment
80. Date of cremation
81. Date of death
82. Date of burial
83. Date of interment
84. Date of cremation
85. Date of death
86. Date of burial
87. Date of interment
88. Date of cremation
89. Date of death
90. Date of burial
91. Date of interment
92. Date of cremation
93. Date of death
94. Date of burial
95. Date of interment
96. Date of cremation
97. Date of death
98. Date of burial
99. Date of interment
100. Date of cremation

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3953

CERTIFICATE OF DEATH

03929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City-15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 3803 Menlo Drive	
3. NAME OF DECEASED (Type or print) Natalie		4. DATE OF DEATH Month April Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1928
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY ILLINOIS	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN WEINE		14. MOTHER'S MAIDEN NAME BERTHA LEVY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.2 Congestive Heart Failure DUE TO (b) Status Epilepticus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 hrs 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 17, 19 59 to April 19, 19 59 , that I last saw the deceased alive on April 19, 19 59 , and that death occurred at 7:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James Donald Drinkard		ADDRESS (Street, city or town, state) Spring Grove State Hospital	
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.		DATE SIGNED 4-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-20-59	22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewin		24a. REC'D BY REGISTRAR APR 21 '59	
ADDRESS 2100 Cutaw Place		24b. REGISTRAR'S SIGNATURE Arthur S. Panga	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3158

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 65</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH April 15, 1934</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>	
<p>DATE OF BIRTH March 1, 1869</p>		<p>PLACE OF BIRTH Maryland</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION Farmer</p>	
<p>RELIGION Methodist</p>		<p>USUAL RESIDENCE Rural</p>	
<p>DATE OF DEATH April 15, 1934</p>		<p>PLACE OF DEATH Home</p>	
<p>CAUSE OF DEATH Heart Disease</p>		<p>IMMEDIATE CAUSE Myocardial Infarction</p>	
<p>DATE OF BIRTH March 1, 1869</p>		<p>PLACE OF BIRTH Maryland</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION Farmer</p>	
<p>RELIGION Methodist</p>		<p>USUAL RESIDENCE Rural</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3954
CERTIFICATE OF DEATH

03930
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle R. Last Bodmer				4. DATE OF DEATH Month April Day 11 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Bodmer		14. MOTHER'S MAIDEN NAME Carrie Wiles		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 6-1-1		17. INFORMANT Clin Records Vet. Adm. Hospital, Ft. Howard, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE BRONCHITIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from April 8, 1959 to April 11, 1959 and that death occurred at 12:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Hiram B. Currey M.D. VAH, Fort Howard, Maryland 4/11/59 PHYSICIAN'S NAME (Type) HIRAM B. CURREY VAH, Fort Howard, Md. 4/11/59 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/15/59 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington, Va. 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661 Good Hope Rd. SE Washington, D. C. 24a. REC'D BY REGISTRAR APR 13 '59 24b. REGISTRAR'S SIGNATURE William S. Fennell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3955

Reg. Dist. No. 03931

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River (20)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 49 Everlasting Lane, Traylor Village		e. STREET ADDRESS 49 Everlasting Lane, Traylor Village	
3. NAME OF DECEASED (Type or print) Ernest Lynnwood Bowles		4. DATE OF DEATH April 1, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Bowles		14. MOTHER'S MAIDEN NAME Mary Rita	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 226-05-9699	
17. INFORMANT Joyce A. Mills		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (b) [a], stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BPH. operated on 2-14-59 Diabetes.		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack C Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack C Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-1-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski		ADDRESS 1407 Eastern Ave.	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Brand	

— 320 —

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2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

• 61 • 01 • 01 • 01 •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3956

CERTIFICATE OF DEATH

03932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 66 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BURTON Middle O Last BROWN				4. DATE OF DEATH Month April Day 10 Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1923	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Howard Brown		14. MOTHER'S MAIDEN NAME Lilly Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-16-0982		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH 162.1 DUE TO METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 3 , 19 59 , to April 10 , 19 59 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD DATE SIGNED							
ACTUAL SIGNATURE Caridad E. Gonzalez M.D.				PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-14-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				24a. REC'D BY REGISTRAR APR 13 1959			
24b. REGISTRAR'S SIGNATURE George G. Kelson				24c. REGISTRAR'S SIGNATURE George G. Kelson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

3957

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT 19</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1017 J Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna H. Wilson Brown</u>		4. DATE OF DEATH Month Day Year <u>April 29, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Color</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 9, 1904</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Felicia Davenport</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-24-0428</u>	
17. INFORMANT <u>Mildred Alston</u>		Address <u>604 Avondale Rd. #22</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>5-6 hr.</u> <u>10 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 12, 1954</u> to <u>April 1959</u> , that I last saw the deceased alive on <u>April 20, 1959</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>140 Oak Ave., Dundalk #22, Md 4-29-59</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24a. REC'D BY REGISTRAR <u>May 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland

10. *Journal of the American Medical Association*, 1977; 237: 1000-1001.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3958 CERTIFICATE OF DEATH

03934

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Owings Mills</u>		LENGTH OF STAY (in this place) <u>9 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Owings Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Pleasant Hill Rd. Owings Mills, Md. Rtd.</u>				STREET ADDRESS (If rural give location) <u>133 Pleasant Hill Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Joseph Francis Brown</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>23</u> (Year) <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/26/1879</u>		9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>His own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Francis Brown</u>				14. MOTHER'S MAIDEN NAME <u>Lavina Feeser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-01-8723</u>		17. INFORMANT & ADDRESS <u>Rd. Owings Mills, Md.</u> <u>Mrs. Claude H. Miller, 133 Pleasant Hill</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Gastric hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gastric Ulcer</u>						<u>2 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic C.V. Disease</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 50</u> , to <u>April 23, 1959</u> , that I last saw the deceased alive on <u>April 23, 1959</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strobel</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Main St. Reisterstown Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>4/26/59</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	
24. REC'D BY REGISTRAR <u>APR 27 '59</u>				REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>	
						LOCATION (City, town, or county) (State) <u>Silver Run, Carroll Co., Md.</u> <u>Littlestown, Pa.</u>	

2252 CERTIFICATE OF DEATH

1913

REGISTRATION DISTRICT

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

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PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

UNCLASSIFIED

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03935

Reg. Dist. No.

3959

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3601-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines-16 Fusting Ave.				d. STREET ADDRESS 849 Hollins St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle L. Last BURKE				4. DATE OF DEATH Month April 17, Day 19 Year 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1878		9. AGE (In years lost birthday) yrs. 80	IF UNDER 1 YEAR Months 3 Days 17 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier (rtd)		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Micheal Burke				14. MOTHER'S MAIDEN NAME Margaret A. Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Self		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma right breast DUE TO (c) 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardio vascular disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10.21.49 , 19 to 4.17.59 , 19, that I last saw the deceased alive on 4.7.59 , 19, and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan Racusin				ADDRESS (Street, city or town, state) 206 S. Gilmore St.		DATE SIGNED 4.18.59	
PHYSICIAN'S NAME (Type) NATHAN RACUSIN, M.D.				Balto 23 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17 Md				24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3960

CERTIFICATE OF DEATH

03936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Allegheny Avenue		d. STREET ADDRESS 1 507 Allegheny Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DORIS Middle EMILY Last BURNS		4. DATE OF DEATH Month April Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse- retired		10b. KIND OF BUSINESS OR INDUSTRY General Nursing	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Burns		14. MOTHER'S MAIDEN NAME Katherine Krantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Conrad Sohn, 507 Allegheny Ave., Towson 4, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS (c) AND HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 30, 1959 , to APRIL 30, 1959 , that I last saw the deceased alive on —, 19— , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T. C. Siwinski M.D. 17 W. PENNA. AVE 5/1/59 PHYSICIAN'S NAME (Type) T. C. SIWINSKI TOWSON 4 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Chibwa & Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3961

CERTIFICATE OF DEATH

03937

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>Graystone Rd.</i>		d. STREET ADDRESS <i>Graystone Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Walter J. Burns</i>		4. DATE OF DEATH <i>April 12, 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 2, 1886</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Block operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
11. BIRTHPLACE (State or foreign country) <i>White Hall, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry P. Burns</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Nelson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>417077916</i>	
17. INFORMANT <i>Pauline M. Burns</i>		Address <i>White Hall Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular disease</i> <i>260x</i> DUE TO <i>Diabetic Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Gangrene - right foot</i> (c) <i>Gangrene - right foot</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 Mo. 1 Wk.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12:55</i> to <i>April 12, 1959</i> , that I last saw the deceased alive on <i>April 12, 1959</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. M. France</i>		ADDRESS (Street, city or town, state) <i>Parkton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>		DATE SIGNED <i>4/14/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 15, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wiseburg Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>White Hall, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Isaac H. Hultstein</i>		ADDRESS <i>New Freedom, Pa.</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 17 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Carroll A. Hultstein</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of developing a business plan is to conduct a thorough market research. This involves identifying the target market, understanding their needs and preferences, and analyzing the competitive landscape. Market research can be conducted through various methods, including surveys, interviews, and focus groups.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
3962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 03938									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE D. C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beltway and Route 40					d. STREET ADDRESS 63rd & Clay Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GOLDY Middle Last BYRON					4. DATE OF DEATH Month April Day 20 Year 1959				
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 18, 1927		9. AGE (In years last birthday) 36 31 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stewardess		10b. KIND OF BUSINESS OR INDUSTRY Pvt. Club		11. BIRTHPLACE (State or foreign country) Charlestown, West Vir.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Harry Lowery					14. MOTHER'S MAIDEN NAME Georgia Burrell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Kenneth M. Byron			Address Wash; D.C. 5235 2nd Street, N.W.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fat embolism complicating multiple traumatic injuries 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto ran off roadway 20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:00 P.M. 4/20/59 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) (County) (State) Baltimore Md.									
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Paul F. Guerin EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/20/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery			22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thomas				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
3RD MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
JAMES J. HANLEY		M		45		W		10/10/1918	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL		10. NAME OF FUNERAL HOME	
11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS		13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS		49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

2465

3963

CERTIFICATE OF DEATH

03939

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7900 Elmhurst Ave.		d. STREET ADDRESS 7900 Elmhurst Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle LEE Last CHASE		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Foreman		10b. KIND OF BUSINESS OR INDUSTRY Glidden Paint	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Chase		14. MOTHER'S MAIDEN NAME Susan Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-7961	
17. INFORMANT Deane Wagner, sister, 1811 Dundalk Ave.		22. ADDRESS 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of LUNG, right (Bronchogenic) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec., 1957 to 4/8 , 1959, that I last saw the deceased alive on 4/6 , 1959, and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11 E. Chase St Baltimore - Md			
ACTUAL SIGNATURE Martin T. Singewald M.D.			
PHYSICIAN'S NAME (Type) MARTIN T. SINGEWALD M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 2931 Brehms Lane		24a. REC'D BY REGISTRAR DATE APR 13 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3964

CERTIFICATE OF DEATH

03940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle L Last CHASE		4. DATE OF DEATH Month April Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1924
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William E. Chase		14. MOTHER'S MAIDEN NAME Dorphine Racks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 217-14-8322	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital Ft Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PORTAL CIRRHOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13 , 19 59 , to April 16 , 19 59 , and that death occurred on 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John W. Crawford M.D. VAH Ft. Howard, Md		4/16/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH Ft. Howard, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-59	
22c. NAME OF CEMETERY OR CREMATORY Williamsburg Cemetery		22d. LOCATION (City, town, or county) (State) Williamsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dashiels Funeral Home Easton, Maryland		24a. REC'D BY REGISTRAR APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

03941
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 19 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LORELEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				1 d. STREET ADDRESS Fullerton R.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OLLIE CHISHOLM				4. DATE OF DEATH Month Day Year APRIL 25 19 59			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-1873	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES LYSANDER HORNBARGER				14. MOTHER'S MAIDEN NAME JOHANNA KYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Fraud L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arterio Sclerotic Cardio (c) Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/18/50 , 19____, to 4/24 , 19 59 , that I last saw the deceased alive on 4/24 , 19 59 , and that death occurred at 7:13 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 4/25/59							
ACTUAL SIGNATURE Water T. Kees				M.D. Cockeysville, Md.			
PHYSICIAN'S NAME (Type) Water T. Kees							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-28-59		22c. NAME OF CEMETERY OR CREMATORY Abingdon Cemetery		22d. LOCATION (City, town, or county) (State) Harford County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
2. Date of death
3. Place of death
4. Cause of death
5. Name of physician
6. Name of funeral home
7. Name of next of kin
8. Signature of registrar
9. Date of registration

CERTIFICATE OF DEATH

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Name of physician		6. Name of funeral home	
7. Name of next of kin		8. Signature of registrar	
9. Date of registration		10. Name of registrar	
11. Name of registrar		12. Name of registrar	
13. Name of registrar		14. Name of registrar	
15. Name of registrar		16. Name of registrar	
17. Name of registrar		18. Name of registrar	
19. Name of registrar		20. Name of registrar	
21. Name of registrar		22. Name of registrar	
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89. Name of registrar		90. Name of registrar	
91. Name of registrar		92. Name of registrar	
93. Name of registrar		94. Name of registrar	
95. Name of registrar		96. Name of registrar	
97. Name of registrar		98. Name of registrar	
99. Name of registrar		100. Name of registrar	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3966

CERTIFICATE OF DEATH

Reg. Dist. No. 03942

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson-</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Cecelia Civis</u>				4. DATE OF DEATH Month Day Year <u>4 3 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Culleton</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Golden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 18, 1959</u> to <u>April 13, 1959</u> , that I last saw the deceased alive on <u>April 3, 1959</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Rd Baltimore, Md.</u> DATE SIGNED <u>4/3/59</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M 050 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3967

CERTIFICATE OF DEATH

Reg. Dist. No.

03943

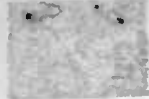
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 29 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 206 North Monastery Avenue			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle F. Last COLLINS				4. DATE OF DEATH Month April Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22, 1912	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper-Social Sec. Federal Government		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Collins				14. MOTHER'S MAIDEN NAME Helen Gambrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 215-09-9268		17. INFORMANT Address Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FIBROSARCOMA OF THE BACK WITH MULTIPLE METASTASIS 197.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 24, 1959 , to April 22, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 1:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FT. HOWARD, MARYLAND DATE SIGNED 4/22/59 ACTUAL SIGNATURE John W. Crawford M.D. VA HOSPITAL, FT. HOWARD, MARYLAND PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D., Acting Chief, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Elroy O. Wilson Funeral Home, 1000 Brantley Ave.				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

Balto., Md.

CERTIFICATE OF DEATH

3181

030



1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
						</																	

1 10 M 050 1 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 10 M 050 1 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3968

CERTIFICATE OF DEATH

Reg. Dist. No.

02729

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE W COMER		4. DATE OF DEATH Mar 11 / Apr 11 2, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Co	
11. BIRTHPLACE (State or foreign country) Comers Rock, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George T Comer		14. MOTHER'S MAIDEN NAME Nancy Cornett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 227-16-7502	
17. INFORMANT Clin. Recs., Vet. Adm. Hospital, Fort Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC GLOMERULONEPHRITIS 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Ventricular Hypertrophy; Coronary Arteriosclerosis with narrowing; Pulmonary Edema; Hypertrophy; Parathyroids		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27, 1959 , to April 2, 1959 , and that death occurred at 5:35 P.M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD	
ACTUAL SIGNATURE John W. Crawford		DATE SIGNED 4/3/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-59	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Funeral Inc., 6009 Harford Rd Balto, Md		24a. REC'D BY REGISTRAR APR 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar	
John Doe		Male		45		1/1/1920		1/15/1965		Baltimore, Md		Baltimore, Md		Heart Disease		Natural		[Signature]		[Signature]	
12. Occupation		13. Education		14. Marital Status		15. Social Security Number		16. Hospital Name		17. Room Number		18. Attending Physician		19. Medical History		20. Postmortem Exam		21. Coroner's Office		22. Burial Place	
Teacher		High School		Married		123-45-6789		St. Mary's		101		Dr. Smith		Hypertension		No		City Hall		Cemetery	
23. Date of Report		24. Registrar's Office		25. Registrar's Name		26. Registrar's Title		27. Registrar's Signature		28. Registrar's Seal		29. Registrar's Stamp		30. Registrar's Address		31. Registrar's Phone		32. Registrar's Fax		33. Registrar's Email	
1/20/1965		City Hall		John Doe		Registrar		[Signature]		[Seal]		[Stamp]		123 Main St		555-1234		555-5678		jdoe@cityhall.gov	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03944

3934

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. LENGTH OF STAY IN 1b 6 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2206 Alletta Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Eva Last Cook				4. DATE OF DEATH Month April Day 24 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1889	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME George Warfield				14. MOTHER'S MAIDEN NAME Mary E. Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Dittman 2206 Alletta Ave. Lansdowne			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-arteriosclerotic CVD DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 15 min years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Colloid goiter						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1944 to April 24, 19 59 , that I last saw the deceased alive on Mar 7, 19 59 , and that death occurred at 5.20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Kennard Yaffe				M.D. 5501 Forest Park Ave 4 -25-59			
PHYSICIAN'S NAME (Type) Kennard Yaffe, M.D.				Baltimore 7, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE Fred A. Cole				ADDRESS 1913 W. Baltimore St.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3969

CERTIFICATE OF DEATH

03945

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 3711 Edgerton Rd.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle CHARLES Last COOK		4. DATE OF DEATH Month April Day 16 , Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer (rtd)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William V. Cook		14. MOTHER'S MAIDEN NAME Annie Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Wm. D. Cook - 86 Samson Ave., Madison, N. J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO advanced arterio-sclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH about 6 days 5 yrs 9			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 10 , 19 59 , to Apr 16 , 19 59 , that I last saw the deceased alive on Apr 16 , 19 59 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4508 N. Charles St. DATE SIGNED _____ ACTUAL SIGNATURE Walter S. Dublitt M.D. Walter S. Dublitt PHYSICIAN'S NAME (Type) Walter S. Dublitt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt		24a. REC'D BY REGISTRAR DATE APR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3970

CERTIFICATE OF DEATH

03946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 100 W. Lake Avenue				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUISA Middle JENKINS Last COOPER				4. DATE OF DEATH Month APRIL Day 19 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1873	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH WILCOX JENKINS				14. MOTHER'S MAIDEN NAME ELLEN ROGERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT: son <input checked="" type="checkbox"/> Address Mr. J. Crossan Cooper - 915 W. Lake Av. (Balto 10			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Arteriosclerotic renal disease DUE TO (b) Arteriosclerosis - generalized DUE TO (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 8, 1953 to APRIL 19, 1959 that I last saw the deceased alive on April 19, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-20-59							
ACTUAL SIGNATURE C. Holmes Boyd, M.D.							
PHYSICIAN'S NAME (Type) C. Holmes Boyd, M. D. 24 East Eager Street, Baltimore 2, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore - Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN COMPANY 108 W. NORTH AVE. CITY				24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3971

03947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nicola Middle Cordone Last Cordone		4. DATE OF DEATH Month 4 Day 3 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXX	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Cordone		14. MOTHER'S MAIDEN NAME Concettine Della	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal bronchopneumonitis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 30, 1959 , to 4-3, 1959 , that I last saw the deceased alive on 4-3, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE JD Drinkard M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED	
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.		CATONSVILLE 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-6-1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt. Rainier, Md.		24. REC'D BY REGISTRAR DATE APR 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3972 CERTIFICATE OF DEATH

03948
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 0627.2			
c. LENGTH OF STAY IN 1b 31 1/2 yrs.				d. STREET ADDRESS Owings Mills, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle Virginia Last Crabbs				4. DATE OF DEATH Month 4 Day 30 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1908		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Morris Crabbs				14. MOTHER'S MAIDEN NAME Bertha Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Rosewood Records		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with uremia. 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Internal hydrocephalus with spastic quadriplegia DUE TO (c) Since birth INTERVAL BETWEEN ONSET AND DEATH Aug. '58							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/26/27 , 19 58 , to 4/30/59 , 19 59 , that I last saw the deceased alive on 4/30/59 , 19 59 , and that death occurred at 12:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 4/30/59							
ACTUAL SIGNATURE Harry B. Butler M.D.				PHYSICIAN'S NAME (Type) Harry B. Butler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-1-59		22c. NAME OF CEMETERY OR CREMATORY Harmony Grove	
22d. LOCATION (City, town, or county) (State) Gist, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John R. Byers Westminster, Md.			
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

13338

CERTIFICATE OF DEATH

13338

State of New York

County of Albany

City of Albany

Dec. 19, 1914

Age 45

Male

Married

Married

White

White

1914

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3973

CERTIFICATE OF DEATH

03949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 622 Stirling St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK A CURETON				4. DATE OF DEATH Month Day Year April 16 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aide		10b. KIND OF BUSINESS OR INDUSTRY Sanitorium		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frank A Cureton				14. MOTHER'S MAIDEN NAME Mary Steel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 108-07-4046		17. INFORMANT Clin. Rec. Vet Adm Hospital Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 24, 1959, to April 16, 1959, that I last saw the deceased alive on March 22, 1959, and that death occurred at 3:10A M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John W. Crawford M.D. VAH Ft Howard, Md 4/16/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips				24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Phillips	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

See Ord. No.

OUTPAT

WIMBOND

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

4. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

5. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

6. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

7. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

8. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

9. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

10. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, State of Maryland, on the _____ day of _____, 19____.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARY LAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex-21</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1315 E. RIVERSIDE DR</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> <u>Czyk</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>6</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 18-1867</u>
9. AGE (In years last birthday) <u>92</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>DONT KNOW</u>	
14. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>215-28-0819</u>		17. INFORMANT Address <u>ADOLPH CZYK-1423 ROBINWOOD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Choking (4" Burns) over</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>entire Body -</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned when home burned to ground</u>	
20c. TIME OF INJURY Month, Day, Year <u>20</u> Hour <u>4/6/59</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Essex-21-Balto-Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHRIST LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDALK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Colin S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3975

03951

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7929 E. Thirty First St.		d. STREET ADDRESS 7929 E. Thirty First St.	
3. NAME OF DECEASED (Type or print) Vincent Joseph Czosnowski		4. DATE OF DEATH Month April Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1898
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Packer		10b. KIND OF BUSINESS OR INDUSTRY S K Co/	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Czosnowski		14. MOTHER'S MAIDEN NAME Teofilina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 213-05-2564	
17. INFORMANT Mrs. Mary Czosnowski		Address 7929 E. 31 st.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1958 to April 1959 , that I last saw the deceased alive on 22nd April 1959 , and that death occurred at 3 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8019 Philadelphia Rd. DATE SIGNED ACTUAL SIGNATURE Joseph E. Schulte, M.D. PHYSICIAN'S NAME (Type) Joseph E. Schulte, M.D. 8019 Philadelphia Rd.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-1959	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 2829 Hudson St. 24, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WHITE HALL</u>		c. LENGTH OF STAY IN 1b <u>11 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WHITE HALL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McCOMAS RD</u>				d. STREET ADDRESS <u>McCOMAS RD.</u>			
3. NAME OF DECEASED (Type or print) <u>WOODROW</u> First <u>WILSON</u> Middle <u>DAILEY</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-14</u>		9. AGE (In years last birthday) <u>44</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONCRETE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			
13. FATHER'S NAME <u>JOSEPH DAILEY</u>			14. MOTHER'S MAIDEN NAME <u>DOWNS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218-10-9577</u>		17. INFORMANT (<u>ELVA C. DAILEY</u>) Address <u>SAME ADDRESS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND, BRAIN</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William A Pillsbury</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/18/59</u>			
EXAMINER'S NAME (Type) <u>WILLIAM A PILLSBURY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 22 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3977

CERTIFICATE OF DEATH

03953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b X RODGERS FORGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1224 DUNKIRK ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle ALBERT Last DEAKINS, III		4. DATE OF DEATH Month APRIL Day 26 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 23 1912
9. AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY RETAIL FURNITURE	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS A. DEAKINS		14. MOTHER'S MAIDEN NAME MARY EDGERTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 578-07-6742	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pleural Effusion. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2002X Diabetes Mellitus & Pulmonary Tuberculosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/19 , 19 59 to 4/26 , 19 59 , that I last saw the deceased alive on 4/26 , 19 59 , and that death occurred at 10:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE W. Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/59	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tischer & Sons - Balt 17		24. REC'D BY REGISTRAR APR 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1900

Name of Deceased _____		Sex _____		Age _____	
Date of Death _____		Time of Death _____		Place of Death _____	
Cause of Death _____		Manner of Death _____		Signature of Physician _____	
Signature of Registrar _____		Signature of Coroner _____		Signature of Medical Examiner _____	
Signature of Health Officer _____		Signature of County Clerk _____		Signature of City Clerk _____	

RECEIVED
BALTIMORE
MAY 10 1900

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BALTIMORE
MAY 10 1900

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

3978

CERTIFICATE OF DEATH

03954

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 28 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7506 Seven Mile Lane				d. STREET ADDRESS 7506 Seven Mile Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle William Last Dell				4. DATE OF DEATH Month April Day 2 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1902		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Procter & Gamble		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George E. Dell				14. MOTHER'S MAIDEN NAME Annie Louise Triplett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-6012		INFORMANT Address Mrs. Ruth Dell 7506 Seven Mile Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MASSIVE MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 17, 1958 to APRIL 2, 1959 , that I lost sow the deceased olive on APRIL 2, 1959 , and that death occurred at 11.30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1331 REISTERSTOWN ROAD 4/3/59 ACTUAL SIGNATURE Samuel P. Scalia M.D. PHYSICIAN'S NAME (Type) PIKESVILLE 8, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Burgee Funeral Home 3631 Falls Road Horace F. Burgee				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3979

CERTIFICATE OF DEATH

03955
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Box 316 Trumps-Mill Rd. about 10 Yrs. Overlea, Balto: Co, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 Trumps Mill Rd. Baltimore Co.		d. STREET ADDRESS 316 Trumps-Mill Rd. Balto: Co.	
3. NAME OF DECEASED (Type or print) First Annie A. Hilbert Last De Vaughn Anna Agnes		4. DATE OF DEATH Month April Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-9-1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 3 Days 27	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress-(Retired)		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas DeV Vaughan	
14. MOTHER'S MAIDEN NAME Maria or Mary Maltowich		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. 214-05-3315		17. INFORMANT Address Mrs. George Goldbeck-Trumps Mill Rd. Balto: Co. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CVD - cerebro vascular accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 months 6 yrs?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb , 19 53 , to April 6 , 19 59 , that I last saw the deceased alive on April 6 , 19 59 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Burton V. Lock MD		ADDRESS (Street, city or town, state) 2936 E. Balto St	
PHYSICIAN'S NAME (Type) BURTON V. LOCK		DATE SIGNED 4/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-9-1959	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Eastern Ave. Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.		ADDRESS -1735 Harford Avenue, Balto. Md.	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thand	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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George J. M. Inc. 1000 Broadway Avenue

CERTIFICATE OF DEATH

Reg. Dist. No.

03956

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fullerton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Whitemarsh Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>M.</u> Last <u>Dieter</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14th</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1870</u>		9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry J. Chetate</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. M. W. 12 5303 Elbrode Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized ARTERIOSCLEROSIS</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peripheral Vascular Disease (Recent Gangrene of Buttocks)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 13, 1959</u> , to <u>April 14, 1959</u> , that I last saw the deceased alive on <u>April 13, 1959</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore E. Evans</u> M.D.				ADDRESS (Street, city or town, state) <u>9660 Belair Rd - 6</u>		DATE SIGNED <u>April 14, 1959</u>	
PHYSICIAN'S NAME (Type) <u>THEODORE E EVANS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3990

1895

<p>1. Name of deceased: <i>Whitmarsh Rd.</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>1870</i></p>		<p>4. Date of death: <i>May 9 1870</i></p>	
<p>5. Place of death: <i>Whitmarsh Rd.</i></p>		<p>6. Cause of death: <i>...</i></p>	
<p>7. Signature of physician: <i>...</i></p>		<p>8. Signature of registrar: <i>...</i></p>	
<p>9. Date of registration: <i>...</i></p>		<p>10. Office of registration: <i>...</i></p>	

RECEIVED BY THE CLERK OF THE BOARD OF HEALTH
BALTIMORE, MARYLAND
MAY 10 1870

3981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03957

CERTIFICATE OF DEATH

1. NAME OF DECEASED
(Type or Print)

Marie A. Dohmer

2. DATE OF DEATH
April 1, 1959

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTIMORE COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Mercy Villa

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
X Sparrows Point

D. STREET ADDRESS (If rural, give location)

Box 272 Dogwood Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Dec. 23, 1880 78

9. AGE (In years
last birthday)

If Under 1 Year If Under 24 Hours

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind
of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Moser

14. MOTHER'S MAIDEN NAME

Pauline Schlaack

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

213-10-1317

17. INFORMANT

ADDRESS

Mrs. Angela Pabich Box 272 19, Md.

18. 332X I

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CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebral Thrombosis 1 yr.

DUE TO

(B) Cerebral Embolism

DUE TO

(C) Hypertension in Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE
TO THE ABOVE CAUSE (A) STATING THE UNDER-
LYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Anemia

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21D. TIME (Month) (Day) (Year) Hour
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 5 1955 to
Sept 1 1959, that (I) (we) last saw the deceased alive on March 14 1959
and that in (my) (our) opinion death occurred at 2:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☐MED. DIRECTOR ☐STAFF PHYS. ☐ M.D.24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

April 4, 1959

Moreland Memorial

Taylor Ave. Md.

DATE RECEIVED BY
REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3982

CERTIFICATE OF DEATH

Reg. Dist. No. 03958

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 Oakdale Ave				d. STREET ADDRESS 123 Oakdale Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWARD NELSON DOYLE				4. DATE OF DEATH Month April Day 23 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1910			
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Catonsville, Md			
11. BIRTHPLACE (State or foreign country) Catonsville, Md				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Anthony Doyle				14. MOTHER'S MAIDEN NAME Sarah Courtney					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2				16. SOCIAL SECURITY NO. 215-05-3164		17. INFORMANT Address Mrs. Blanche Doyle, Catonsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardio-Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Myocardial Degeneration & Hypertrophy								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from Feb , 1959, to 23 April , 1959, that I last saw the deceased alive on 23 April , 1959, and that death occurred at 2:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondy Ave Balto 29 DATE SIGNED 24 April 59									
ACTUAL SIGNATURE William J. Bryson				M.D. 4605 Edmondy Ave Balto 29					
PHYSICIAN'S NAME (Type) W. J. Bryson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE APR 27 59		24b. REGISTRAR'S SIGNATURE Charles L. Thorne			

CERTIFICATE OF DEATH

3942

87008

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "11-1-1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "C. D. Brown"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF NEAREST RELATIVE [Faint text, possibly "Mrs. J. Doe"]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

The Registrar of the State Department of Health, Baltimore, Maryland, is authorized to issue a certificate of death to the nearest relative of the deceased, or to the person in charge of the funeral home, upon the presentation of this certificate.

The Registrar of the State Department of Health, Baltimore, Maryland, is authorized to issue a certificate of death to the nearest relative of the deceased, or to the person in charge of the funeral home, upon the presentation of this certificate.

3983

CERTIFICATE OF DEATH

03959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>419 Stevenson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Anna Louise Dumler</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Trost</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Joseph J. Dumler, Jr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic blood disease</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes + age</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>15 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1948</u> , to <u>April, 1959</u> , that I last saw the deceased alive on <u>May 3, 1958</u> , and that death occurred at <u>11 p. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2429 N. Charles - Balto 18, Md</u> DATE SIGNED <u> </u> ACTUAL SIGNATURE <u>Franklin E. Leslie</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 1959</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6242 5-6-59 et

3984

CERTIFICATE OF DEATH

03960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>3 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Woodlawn)</u> d. STREET ADDRESS <u>Ridge Road & Croft Lane (7)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>EDWARD</u> <u>Middle</u> <u>D.</u> <u>Last</u> <u>ECCLI</u>		4. DATE OF DEATH <u>Month</u> <u>April</u> <u>Day</u> <u>29</u> <u>Year</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 17, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Roads</u>	9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Eccli</u>		14. MOTHER'S MAIDEN NAME <u>Lily Geddes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Clinical Records, VA Hospital, Ft. Howard, Md.</u>	
17. INFORMANT <u>Clinical Records, VA Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>3 Months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death Immediate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26, 1959</u> , to <u>April 29, 1959</u> , that I last saw the deceased alive on <u>April 29, 1959</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4/29/59</u>			
ACTUAL SIGNATURE <u>John W. Crawford</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Tickner & Sons, Inc. North & Penna. Aves. Baltimore, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE APR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1910-01-01		1955-03-15		Baltimore, MD		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of cemetery		20. Name of undertaker	
Teacher		High School		Married		Baltimore, MD		Baltimore, MD		Dr. Smith		St. Mary's		Doe & Sons		Greenwood		Doe & Sons	
21. Name of informant		22. Relationship to deceased		23. Address of informant		24. Telephone number		25. Date of completion		26. Signature of informant		27. Signature of registrar		28. Signature of physician		29. Signature of funeral home		30. Signature of cemetery	
Jane Doe		Wife		123 Main St		555-1234		1955-03-15		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3985

CERTIFICATE OF DEATH

03961

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE <u>2428 Brunswick Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Richard</u> Last <u>Eckman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1897</u>
9. AGE (In years last birthday) yrs. <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Signalman RR Wash. Term. Div.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Eckman</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Trezie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>718-149204</u>	
17. INFORMANT <u>Mrs. Hazel Eckman</u>		Address <u>2428 Brunswick</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>8 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1959</u> to <u>April 18, 1959</u> , that I last saw the deceased alive on <u>April 16, 1959</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Ellsworth Cook</u>		M.D. <u>2431 Maryland Ave</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>4-18-59</u>	
PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u>		<u>Balto. 18 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkenna Avenue</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

070111 163

5438 Brunswick Road

Elkridge, Maryland

02/15/4

HOWARD H. HUBBARD 4107 WILKENS AVENUE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3986

CERTIFICATE OF DEATH

03962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS				c. LENGTH OF STAY IN 1b 84ys-4mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING SCHOOL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 7505 LARGE STREET							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ROBERT EDER				4. DATE OF DEATH Month Day Year APRIL 6 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 2, 1942 yrs. 17	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD L. EDER				14. MOTHER'S MAIDEN NAME ANNA MYRTLE MAURER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address ROSEWOOD RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LOBAR PNEUMONIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SPASTIC QUADRIPLEGIA-BEDRIDDEN 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from April 5, 1959 , to April 6, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 12:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 416/59 DATE SIGNED ACTUAL SIGNATURE Ernest J. Decko M.D. ROSEWOOD LANE OWINGS MILLS PHYSICIAN'S NAME (Type) ERNEST J. DECKO M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-9-59		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) BALTO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Seiler 9015 CONKLING ST. BALTO., 24, MD.				24a. REC'D BY REGISTRAR DATE APR 9 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Thorne	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1036106-24

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
3987 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03963

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. LENGTH OF STAY IN 1b <u>54 MIDDLE RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 MIDDLE RIVER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>152 KINGSTON RD.</u>			d. STREET ADDRESS <u>152 KINGSTON RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN KATHERINE EFFORD</u>			4. DATE OF DEATH Month Day Year <u>APRIL 19 1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 18-1911</u>		9. AGE (In years last birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ELMER JOHNSON</u>		
14. MOTHER'S MAIDEN NAME <u>ISABELLE COLBURN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>IRA EFFORD JR. 152 KINGSTON RD.</u>			17. INFORMANT Address <u>IRA EFFORD JR. 152 KINGSTON RD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension + Rheumatic</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C-V-Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5</u> —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/21/59</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
22d. LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u>	
23. FUNERAL DIRECTOR'S ADDRESS <u>418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR <u>APR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

3988

CERTIFICATE OF DEATH

03964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5539 Channing Road</i>		d. STREET ADDRESS <i>1 5539 Channing Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Albert L. Emge</i>		4. DATE OF DEATH <i>April 15th 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 20, 1918</i>
9. AGE (In years last birthday) <i>40</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Administrative Asst. U.S. Government</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Albert Emge</i>	
14. MOTHER'S MAIDEN NAME <i>Lucy V. Lawson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>219-01-4016</i>		17. INFORMANT Address <i>Mrs. Audrey Emge 5539 Channing Road.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1 ympho-sarcoma</i> DUE TO 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 19 53</i> , to <i>April 15, 19 59</i> , that I last saw the deceased alive on <i>April 14, 19 59</i> , and that death occurred at <i>9:10 A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Nelson Mc Kay</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>6014 Edmonson Ave. Balto. Md. 4-15-59</i>	
PHYSICIAN'S NAME (Type) <i>J. Nelson Mc Kay</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/17/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Balto. National Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 20 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the name of the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3989

CERTIFICATE OF DEATH

03965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1013 Hallimont Rd.</u>		d. STREET ADDRESS <u>1013 Hallimont Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Lloyd Eney</u>		4. DATE OF DEATH Month Day Year <u>April 25 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1955</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>	
11. BIRTHPLACE (State or foreign country) <u>Columbus, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd H. Eney Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice B. Hannam</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>Mr. Lloyd H. Eney Jr.</u>		Address <u>1013 Hallimont Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myxosarcoma - Retropharyngeal</u> <u>148x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/30</u> , 1958, to <u>4/25</u> , 1959, that I last saw the deceased alive on <u>4/15</u> , 1959, and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Edward L. Frey Jr.</u> M.D.		<u>4605 EDMONDSON AVE.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD L. FREY, JR.</u>		<u>BALTO. 29, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

CERTIFICATE OF DEATH

1917

1-1-17

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 1, 1917</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>[Signature]</u></p>	
<p>8. Signature of registrar: <u>[Signature]</u></p>	
<p>9. Date of registration: <u>Jan 1, 1917</u></p>	
<p>10. Place of registration: <u>Baltimore</u></p>	
<p>11. Name of registrar: <u>[Name]</u></p>	
<p>12. Name of physician: <u>[Name]</u></p>	
<p>13. Name of informant: <u>[Name]</u></p>	
<p>14. Name of informant: <u>[Name]</u></p>	
<p>15. Name of informant: <u>[Name]</u></p>	
<p>16. Name of informant: <u>[Name]</u></p>	
<p>17. Name of informant: <u>[Name]</u></p>	
<p>18. Name of informant: <u>[Name]</u></p>	
<p>19. Name of informant: <u>[Name]</u></p>	
<p>20. Name of informant: <u>[Name]</u></p>	
<p>21. Name of informant: <u>[Name]</u></p>	
<p>22. Name of informant: <u>[Name]</u></p>	
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<p>97. Name of informant: <u>[Name]</u></p>	
<p>98. Name of informant: <u>[Name]</u></p>	
<p>99. Name of informant: <u>[Name]</u></p>	
<p>100. Name of informant: <u>[Name]</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3990

CERTIFICATE OF DEATH

03966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b X Harbor View	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hill Nursing and Conv.Home		d. STREET ADDRESS 518 S. 48th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN F. ENGELMEYER		4. DATE OF DEATH Month April Day 22 Year 19 59.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1882
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Engelmeyer		14. MOTHER'S MAIDEN NAME Mary Wernig.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Marie I. Droll		Address 518 S. 48th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15/57 , 19 57 , to 4/22 , 19 59 , that I last saw the deceased alive on 4/13/59 , 19 59 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7422 Eastern Ave Baltimore 24 Md.	
ACTUAL SIGNATURE Max Baum		DATE SIGNED 4/24/59	
PHYSICIAN'S NAME (Type) MAX BAUM		ADDRESS Baltimore 24 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-25-59	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gailer		ADDRESS 9015 CONKLING ST. BALTO., 24, MD.	
24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Charles J. Gailer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

00000

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1945	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
RESIDENT OF		DATE OF BIRTH	
Baltimore, Md.		Jan 15 1880	
MARITAL STATUS		PREVIOUS MARRIAGES	
Married		None	
FATHER'S NAME		MOTHER'S NAME	
John H. Harris		Mary E. Harris	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
Carpenter		Homemaker	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Maryland		Maryland	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
Jan 15 1855		Jan 15 1855	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
Maryland		Maryland	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
Natural		Natural	
FATHER'S RESIDENT ADDRESS		MOTHER'S RESIDENT ADDRESS	
1234 Main St.		1234 Main St.	
FATHER'S PHONE NUMBER		MOTHER'S PHONE NUMBER	
1234		1234	
FATHER'S SOCIAL SECURITY NUMBER		MOTHER'S SOCIAL SECURITY NUMBER	
1234 56789		1234 56789	
FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS	
Married		Married	
FATHER'S PREVIOUS MARRIAGES		MOTHER'S PREVIOUS MARRIAGES	
None		None	
FATHER'S DATE OF MARRIAGE		MOTHER'S DATE OF MARRIAGE	
Jan 15 1910		Jan 15 1910	
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE	
Maryland		Maryland	
FATHER'S CAUSE OF MARRIAGE		MOTHER'S CAUSE OF MARRIAGE	
Love		Love	
FATHER'S MANNER OF MARRIAGE		MOTHER'S MANNER OF MARRIAGE	
Legal		Legal	
FATHER'S RESIDENT ADDRESS		MOTHER'S RESIDENT ADDRESS	
1234 Main St.		1234 Main St.	
FATHER'S PHONE NUMBER		MOTHER'S PHONE NUMBER	
1234		1234	
FATHER'S SOCIAL SECURITY NUMBER		MOTHER'S SOCIAL SECURITY NUMBER	
1234 56789		1234 56789	
FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS	
Married		Married	
FATHER'S PREVIOUS MARRIAGES		MOTHER'S PREVIOUS MARRIAGES	
None		None	
FATHER'S DATE OF MARRIAGE		MOTHER'S DATE OF MARRIAGE	
Jan 15 1910		Jan 15 1910	
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE	
Maryland		Maryland	
FATHER'S CAUSE OF MARRIAGE		MOTHER'S CAUSE OF MARRIAGE	
Love		Love	
FATHER'S MANNER OF MARRIAGE		MOTHER'S MANNER OF MARRIAGE	
Legal		Legal	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF REGISTERING THE DEATH OF THE DECEASED IN THE STATE OF MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3991

CERTIFICATE OF DEATH

Reg. Dist. No.

03967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>15 MONTHS</u>				24 3401-11			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the PINES</u>				d. STREET ADDRESS <u>100 N. Highland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN "G" ENGNOTH</u>				4. DATE OF DEATH Month Day Year <u>APR 19 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 AUG 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICKLAYER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>NATURALIZED USA</u>							
13. FATHER'S NAME <u>CHARLES ENGNOTH</u>				14. MOTHER'S MAIDEN NAME <u>Amelia MARKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		(If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Milton H. Eggnoth 3309 Alameda Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, L femoral artery</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>>10 years</u> <u>>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 June 1956</u> to <u>18 Apr 1959</u> , that I last saw the deceased alive on <u>18 Apr 1959</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Conrad Acton M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>1208 St Paul St. Baltimore 2, Md.</u>			
DATE SIGNED <u>19 Apr 59</u>							
PHYSICIAN'S NAME (Type) <u>CONRAD ACTON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 April 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

45385

NAME OF DECEASED		DATE OF DEATH	
JOHN A. MOORE		APRIL 28 1900	
AGE		SEX	
50		M	
RACE		RELIGION	
W		M	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
EDUCATION		OCCUPATION	
HIGHER SCHOOL		CLOCK MAKER	
MARRIED		SINGLE	
YES		NO	
NAME OF SPOUSE		NAME OF SPOUSE	
MILTON B. MOORE		MILTON B. MOORE	
DATE OF MARRIAGE		DATE OF MARRIAGE	
JAN 1 1898		JAN 1 1898	
PLACE OF MARRIAGE		PLACE OF MARRIAGE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF DEATH		DATE OF DEATH	
APRIL 28 1900		APRIL 28 1900	
TIME OF DEATH		TIME OF DEATH	
10:30 AM		10:30 AM	
NAME OF PHYSICIAN		NAME OF PHYSICIAN	
J. A. MOORE		J. A. MOORE	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF BURIAL		DATE OF BURIAL	
APRIL 28 1900		APRIL 28 1900	
NAME OF BURIAL PLACE		NAME OF BURIAL PLACE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEATH RECORD ACT OF 1898.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG241 4-20-59 et
3992
CERTIFICATE OF DEATH

03968
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Erickson Last		4. DATE OF DEATH Month April Day 9 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1971 1880
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin Mill ret		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dont Know		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs Anna M Ashton 8108 Long Point Road	
17. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Degenerative Heart Disease Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/8/59 to 4/9/59 , that I last saw the deceased alive on 4/8/59 , 19 59 , and that death occurred at 1:50 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville 28md 4/9/59	
ACTUAL SIGNATURE W.E. McGroth		M.D. W.E. McGroth	
PHYSICIAN'S NAME (Type) W.E. McGroth			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF April 11/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Balto Co
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave		24a. REC'D BY REGISTRAR DATE APR 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03969

3993
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN lb 8 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) 6830 Windsor Mill Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 6830 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Minnie M. Flora First Middle Last		4. DATE OF DEATH April 24 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug: 10 1875 9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Schwartz		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Charles I. Flora--6830 Windsor Mill Rd Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL Embolism 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIO SCLEROTIC VASCULAR DISEASE DUE TO (c) SENILITY		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 6YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JULY 23, 1953 , to APRIL 24, 1959 , that I last saw the deceased alive on APRIL 24, 1959 , and that death occurred at 10:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 Old Frederick Road-Balto 29 DATE SIGNED ACTUAL SIGNATURE Melvin N. Borden M.D. PHYSICIAN'S NAME (Type) Melvin N. Borden M.D. 5000 BALTIMORE NATIONAL PIKE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 27/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Whippert ADDRESS 1300 Eutaw Place		24a. RECEIVED BY REGISTRAR APR 28 1959	24b. REGISTRAR'S SIGNATURE Charles I. Flora

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR OFFENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or offending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3994

CERTIFICATE OF DEATH

03970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4518 Kenwood Ave</u>		d. STREET ADDRESS <u>4518 Kenwood Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>John</u> Last <u>Folker</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry John Folker</u>		14. MOTHER'S MAIDEN NAME <u>Helena Halso</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anna M Folker</u>		Address <u>4518 Kenwood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Absorption</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic Carcinoma, Right</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>9 Hours</u> <u>9 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1, 1958</u> , to <u>April 22, 1959</u> , that I last saw the deceased alive on <u>April 13, 1959</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Damsch</u> M.D. <u>4636 Belair Road</u>		DATE SIGNED <u>4-22-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR MD M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hyppel Bros</u> ADDRESS <u>7110 BELAIR RD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hama</u>	

WILEY

CERTIFICATE OF DEATH

Reg. Dist. No. 03971

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3047 Woodside Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Sophia Franz</i>		4. DATE OF DEATH <i>April 4th 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 23, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Schmidt</i>		14. MOTHER'S MAIDEN NAME <i>Eilhelmina Eckhardt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. John J. Franz</i>		Address <i>3047 Woodside Avenue</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> <i>153.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of descending colon</i> DUE TO (c) <i>16 mo.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 1958</i> , to <i>April 4, 1959</i> , that I last saw the deceased alive on <i>April 3, 1959</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold A. Grott</i> M.D.		ADDRESS (Street, city or town, state) <i>8100 Harford Rd - Baltimore, Md.</i>	
DATE SIGNED <i>4/14/59</i>			
PHYSICIAN'S NAME (Type) <i>HAROLD A. GROTT, M.D. Balto. 14, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/7/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road</i>	
24a. REC'D BY REGISTRAR <i>APR 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02871

1911

PLACE OF DEATH HOME		MARRIAGE	
DATE OF DEATH JAN 20 1911		DATE OF MARRIAGE JAN 20 1911	
NAME OF DECEASED JOHN J. JONES		NAME OF SPOUSE JANE J. JONES	
AGE 35		AGE 35	
SEX MALE		SEX FEMALE	
RACE WHITE		RACE WHITE	
BIRTH JAN 20 1876		BIRTH JAN 20 1876	
PLACE OF BIRTH BALTIMORE, MD		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION CLOCK MAKER		OCCUPATION CLOCK MAKER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. JONES		SIGNATURE OF PHYSICIAN J. H. JONES	
DATE OF SIGNATURE JAN 20 1911		DATE OF SIGNATURE JAN 20 1911	
PLACE OF SIGNATURE BALTIMORE, MD		PLACE OF SIGNATURE BALTIMORE, MD	
SIGNATURE OF REGISTRAR J. H. JONES		SIGNATURE OF REGISTRAR J. H. JONES	
DATE OF SIGNATURE JAN 20 1911		DATE OF SIGNATURE JAN 20 1911	
PLACE OF SIGNATURE BALTIMORE, MD		PLACE OF SIGNATURE BALTIMORE, MD	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3925

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03972
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turners Station				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 17 Woodland Avenue				d. STREET ADDRESS 17 Woodland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle CHARLES Last FREEMAN				4. DATE OF DEATH Month April Day 13th , Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1959	
9. AGE (In years last birthday) --- yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert S. Freeman		14. MOTHER'S MAIDEN NAME Mary Narowansky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Mary N. Freeman same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7720 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malaria Infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3-4 26 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Inc. Dundalk 22				24a. REC'D BY REGISTRAR APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED HOBBS, J. J.		AGE 35		SEX Male		RACE White		DATE OF DEATH April 21, 1939		PLACE OF DEATH Home	
RESIDENCE 17 Washington Avenue		CITY Baltimore		COUNTY Baltimore		STATE Maryland		DATE OF BIRTH April 19, 1904		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION None		EDUCATION None		MARRIAGE None		RELIGION None		DATE OF MARRIAGE None		PLACE OF MARRIAGE None	
CAUSE OF DEATH None		MANNER OF DEATH None		DISEASE None		SYMPTOMS None		TREATMENT None		POST-MORTEM None	
SIGNATURE OF EXAMINER None		TITLE None		DATE None		PLACE None		COUNTY None		STATE None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3996

CERTIFICATE OF DEATH

03973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 22yr9mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
f. STREET ADDRESS 1729 Bank Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leah First Friedmann Middle Friedmann Last		4. DATE OF DEATH April Month 19 Day 19 Year 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania ✓	
13. FATHER'S NAME Katus		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 to April 19, 1959 , that I last saw the deceased alive on April 19, 1959 , and that death occurred at 6:30a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-20-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Ches Shalom		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joe Jensen		ADDRESS 4124 - 1124-26 W. North Ave	
24a. REC'D BY REGISTRAR APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

(continued from page 60)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3997

Items 8, 9 Film G242 5-19-59 et

CERTIFICATE OF DEATH

03974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND <u>Catonsville</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>3Y01-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 8 mo 30 d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City (Balto 26)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>1523 Locust St.</u>			
3. NAME OF DECEASED (Type or print) <u>Stanislaw</u> Middle <u>Frydrychowski</u> or <u>James</u> Frederick				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877</u> <u>5-8-11/30</u>		9. AGE (In years last birthday) <u>77</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Moulder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight car wheels</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-3813</u>		17. INFORMANT Address <u>Records from Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 19</u> , 19 <u>55</u> , to <u>April 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>59</u> , and that death occurred at <u>9:20</u> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>1012 HARTMONT RD.</u> PHYSICIAN'S NAME (Type) <u>ARISTIDE S. M. SIMOPOULOS</u> <u>BALTO. 28 Md.</u> DATE SIGNED <u>4-18-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>			
22d. LOCATION (City, town, or county) <u>A. A. Co.</u>		(State) <u>Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Fralbaugh</u> ADDRESS <u>2007</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3998

CERTIFICATE OF DEATH

03975

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home				d. STREET ADDRESS Nicodemus Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Margaret Last Gamber				4. DATE OF DEATH Month April Day 9 Year 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 11 1872		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY =		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Tillman				14. MOTHER'S MAIDEN NAME Susanna Eckman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Ville Md Mrs Daniel Wilson 17 Walker Ave Pikesville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA DUE TO (c) ARTERIO SCLEROTIC C.V.D.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/15 , 19 59 to 4/10 , 19 59 , that I last saw the deceased alive on 4/10 , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John H. Shaw M.D. 5800 EDMONDSON AVE 4/10/59 PHYSICIAN'S NAME (Type) John H. Shaw M.D. B.A.L. 28, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 12 1959	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons				24a. REC'D BY REGISTRAR DATE APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03976

3999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. LENGTH OF STAY IN 1b <u>45 yrs.</u> * <u>Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8402 Philadelphia Rd.</u>		d. STREET ADDRESS <u>8402 Philadelphia Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Fernandez</u> Middle <u>Garcia</u> Last		4. DATE OF DEATH <u>April</u> Month <u>24</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Business Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Welding Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Garcia</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-05-1011</u>	
17. INFORMANT <u>Mrs. Elma Garcia</u> Address <u>8402 Philadelphia Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Haemorrhage</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Pancreas</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>58</u> , to <u>April 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D. <u>Baltimore Md</u>		DATE SIGNED <u>4/24/59</u>	
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Fairbank</u> ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>APR 27 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

08076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>10-15-1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. RACE <i>White</i>		9. RELIGION <i>Catholic</i>		10. EDUCATION <i>High School</i>		11. SOCIAL SECURITY NUMBER <i>123-45-6789</i>		12. DATE OF DEATH <i>11-10-1955</i>	
13. TIME OF DEATH <i>10:30 AM</i>		14. PLACE OF DEATH <i>Home</i>		15. CAUSE OF DEATH <i>Heart Disease</i>		16. MANNER OF DEATH <i>Natural</i>		17. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF WITNESSES <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3935

CERTIFICATE OF DEATH

Reg. Dist. No.

03977

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4601 Leeds Ave				e. STREET ADDRESS 1 4601 Leeds Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle GILBERT Last				4. DATE OF DEATH Month April Day 7 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1887		9. AGE (In years and birth day) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Gilbert				14. MOTHER'S MAIDEN NAME Theresa Ames			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216 01 7197		17. INFORMANT Margaret Gilbert, 4601 Leeds Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 352X DUE TO Coronary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis (Right Side) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 6/4/59	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1958 to April 7, 1959 , that I last saw the deceased alive on April 7, 1959 , and that death occurred at 2 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Katz				ADDRESS (Street, city or town, state) 4123 Frederick Ave		DATE SIGNED 4/8/59	
PHYSICIAN'S NAME (Type) Dr. Katz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DATE APR 10 '59	
				24b. REGISTRAR'S SIGNATURE Carl S. Ames			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

206-8044
R-740
3-4
4/23 Frederick Ave
Dr. Katz
0

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: Jan 15, 1945]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: Clerk]		MARITAL STATUS [Handwritten: Married]		EDUCATION [Handwritten: High School]	
SIGNATURE OF DECEASED [Handwritten: John Doe]		SIGNATURE OF WITNESS [Handwritten: Jane Doe]		SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]	
SIGNATURE OF CLERK [Handwritten: John Doe]		SIGNATURE OF REGISTRAR [Handwritten: Jane Doe]		SIGNATURE OF JUDGE [Handwritten: Dr. Smith]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body of the deceased, or by the registrar or other qualified person who has attended the deceased, or by the judge or other qualified person who has examined the body of the deceased.

The certificate shall be signed by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body of the deceased, or by the registrar or other qualified person who has attended the deceased, or by the judge or other qualified person who has examined the body of the deceased.

The certificate shall be signed by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body of the deceased, or by the registrar or other qualified person who has attended the deceased, or by the judge or other qualified person who has examined the body of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4000

CERTIFICATE OF DEATH

Reg. Dist. No.

03978

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3613 Kenmar Road		d. STREET ADDRESS 3613 Kenmar Road #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DORIS		4. DATE OF DEATH April 2, 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 21, 1887	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eugene Harris		14. MOTHER'S MAIDEN NAME Clara Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Lt. Col. Brune N. Gillaspey-3725 Washington Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastric Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. disease DUE TO (c) Cardiac Embolus INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1953 , to April 2nd, 1959 , that I last saw the deceased alive on April 2, 1959 and that death occurred at 2331 M. from the causes and on the date stated above. ADDRESS (street, city or town, state) Baltimore, Md. DATE SIGNED 4/4/59 ACTUAL SIGNATURE Thomas E. Wheeler M.D. Thomas E. Wheeler PHYSICIAN'S NAME (Type) Thomas E. Wheeler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/59	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner ADDRESS Balto - 17. Md.		24a. REC'D BY REGISTRAR APR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03979

4001

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURS. HOME		d. STREET ADDRESS 1529 POPLAR GROVE ST.	
3. NAME OF DECEASED (Type or print) First Middle Last EUGENIA M. GILROY		4. DATE OF DEATH Month Day Year APRIL 6, 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 24, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCOIS DALBY		14. MOTHER'S MAIDEN NAME MARIE PASQUET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. 579-12-7549	
17. INFORMANT Address MR. CHARLES V. GUNDINA 5200 OLD FREDERICK RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Colloid Goiter			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 6 April 59 , that I last saw the deceased alive on 6 April 1959 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Mc Grath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 7 April 59	
PHYSICIAN'S NAME (Type) W. E. Mc Grath			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 9/59	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIR. 4101 EDMONDSON AVE		24a. REC'D BY REGISTRAR APR 9 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DEATH

0000



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CERTIFICATE OF DEATH" and "0000" are visible.]

4002

CERTIFICATE OF DEATH

Reg. Dist. No.

03980

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville, Balto. Co.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOTTIE M. GIMPEL</u>		4. DATE OF DEATH <u>April 25</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sumner S. Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Frank Gimpel, Columbus Ohio</u>	
17. INFORMANT <u>Frank Gimpel, Columbus Ohio</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER OF RECTO-SIGMOID & COLONY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>58</u> , to <u>4/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>59</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff &</u> M.D. <u>4605 Ed. Morden</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/25/59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>BALTIMORE 29 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/29/59</u>	<u>Springfield</u>	<u>Catonsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03981

Reg. Dist. No.

3936

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>817 Sulphur Spring Rd</u>		d. STREET ADDRESS <u>1817 Sulphur Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Annie Godelesky</u>		4. DATE OF DEATH <u>April 24</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1988</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Stanley Godelesky</u>		Address <u>817 Sulphur Sp. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronaries occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic C.V.D.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 15, 1958</u> , to <u>April 24, 1959</u> , that I last saw the deceased alive on <u>April 24, 1959</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley Ankuhas</u> M.D.		ADDRESS (Street, city or town, state) <u>1803 W. 13th, Balt</u> DATE SIGNED <u>4.25.59</u>	
PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase Inc. 1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR <u>APR 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Thane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

10000

NAME OF DECEASED WILLIAM B. BROWN		AGE 45	SEX M	RACE W	DATE OF BIRTH 1900	PLACE OF BIRTH MD
RESIDENCE 1234 E. MAIN ST. BALTIMORE, MD		OCCUPATION CLERK				CAUSE OF DEATH HEART DISEASE
DATE OF DEATH 1935		PLACE OF DEATH HOME				TIME OF DEATH 10:00 AM
SIGNATURE OF DECEASED WILLIAM B. BROWN		SIGNATURE OF WITNESSES J. B. SMITH				DATE OF SIGNATURE 1935
SIGNATURE OF PHYSICIAN D. C. JONES		DATE OF SIGNATURE 1935				PLACE OF SIGNATURE BALTIMORE, MD
SIGNATURE OF CORONER JOHN D. WHITE		DATE OF SIGNATURE 1935				PLACE OF SIGNATURE BALTIMORE, MD
SIGNATURE OF REGISTRAR MARY E. GREEN		DATE OF SIGNATURE 1935				PLACE OF SIGNATURE BALTIMORE, MD

4003

Items 12, 14 Film G241 4-27-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 03982

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Victoria Rd</u>		d. STREET ADDRESS <u>13 Victoria Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Goetze</u> Last <u>Goetze</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rumaria</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Schwabe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shvale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Walter Goetze 3 Victoria Rd.</u>	
17. INFORMANT <u>Walter Goetze 3 Victoria Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage, Apoplexy</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & Arteriosclerosis, generalized</u>			
(c) <u>none</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 11</u> , 19 <u>59</u> , to <u>April 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving R. Beck</u> M.D. <u>901 Fausch Ave</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>IRVING R. BECK M.D.</u>		<u>Baltimore Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marshall Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>308 Hartford Rd</u>		24b. REC'D BY REGISTRAR DATE <u>APR 23 '59</u>	24c. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4004

CERTIFICATE OF DEATH

03983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3500 Devonshire Drive	
3. NAME OF DECEASED (Type or print) First Hannah Middle Hirschberg Last Gradman		4. DATE OF DEATH Month April Day 16 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1894
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME Moritz Hirschberg		14. MOTHER'S MAIDEN NAME Sretta Fromm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerotic nephrosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12, 1959 to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 9:45a , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-16-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-17-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Rosedale		22d. LOCATION (City, town or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutan Pl	
24a. REC'D BY REGISTRAR APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF DECEASED		24. SIGNATURE OF NEXT OF KIN		25. SIGNATURE OF DECEASED	
26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF DECEASED		28. SIGNATURE OF NEXT OF KIN		29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF DECEASED	
36. SIGNATURE OF NEXT OF KIN		37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF DECEASED		40. SIGNATURE OF NEXT OF KIN	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF DECEASED		48. SIGNATURE OF NEXT OF KIN		49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF DECEASED	
56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF DECEASED		60. SIGNATURE OF NEXT OF KIN	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF DECEASED		64. SIGNATURE OF NEXT OF KIN		65. SIGNATURE OF DECEASED	
66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF DECEASED		68. SIGNATURE OF NEXT OF KIN		69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF NEXT OF KIN		77. SIGNATURE OF DECEASED		78. SIGNATURE OF NEXT OF KIN		79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF DECEASED		84. SIGNATURE OF NEXT OF KIN		85. SIGNATURE OF DECEASED	
86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF DECEASED		88. SIGNATURE OF NEXT OF KIN		89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF DECEASED		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF DECEASED	
96. SIGNATURE OF NEXT OF KIN		97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF DECEASED		100. SIGNATURE OF NEXT OF KIN	

RECEIVED

1

20. ATTENTION OF
THE REGISTRAR
OF DEATHS
BOSTON, MASS.
JAN 1 1900

* MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03984

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		d. STREET ADDRESS 1614 1601 E. Lanvale Street	
3. NAME OF DECEASED (Type or print) First Major Middle ----- Last GRAY		4. DATE OF DEATH Month 4 Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unkown		14. MOTHER'S MAIDEN NAME Unkown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-0754	
17. INFORMANT Edith Mae Gray		Address 1614 E. Lanvale St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMPOUND FRACTURE OF SKULL 9/10.3 DUE TO Fracture of Right Frontal and Occipital Areas</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) _____</p> <p>(c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH Instantaneous</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heavy Scrap Bucket fell on his head	
20c. TIME OF INJURY Month, Day, Year 4:35 o. m. 4-18-59 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pipe Mill B.S.CO.		20f. (City or town) (County) (State) Sparrows Point Balt. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis MD		DATE SIGNED 4/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/59	
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy D. Wilson		24a. REC'D BY REGISTRAR APR 20 '59	
ADDRESS 1041 Bunting		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

03

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
LOCALITY		CITY		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
HISTORY OF ILLNESS		PREVIOUS ILLNESS		TREATMENT		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO	
PHYSICAL EXAMINATION		VITAL SIGNS		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		HISTOPATHOLOGICAL EXAMINATIONS		TOXICOLOGICAL EXAMINATIONS	
POST-MORTEM EXAMINATION		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	
AUTOPSY REPORT		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	
LABORATORY REPORT		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	
RADIOLOGICAL REPORT		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	
HISTOPATHOLOGICAL REPORT		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	
TOXICOLOGICAL REPORT		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMICAL FINDINGS		IMMUNOHISTOCHEMICAL FINDINGS		CYTOGENETIC FINDINGS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4006

CERTIFICATE OF DEATH

03985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 103 Cemetery Avenue	
3. NAME OF DECEASED (Type or print) RODNEY LEE GRAY		4. DATE OF DEATH Month April Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman - Retired		10b. KIND OF BUSINESS OR INDUSTRY Commercial Fishing Elliott, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Gray		14. MOTHER'S MAIDEN NAME Delita Ann Harshman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 5 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 13, 1959 , to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 9:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FT. HOWARD, MARYLAND 4/22/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VA HOSPITAL, FT. HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D., Acting Chief, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-24-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. 14		ADDRESS	
24a. REC'D BY REGISTRAR APR 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Shipped to: W.W. Chambers, 1400 Chapin St. N.W. Wash. D.C. Md.

265

4007

CERTIFICATE OF DEATH

03986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 OAK MERE RD.</u>				d. STREET ADDRESS <u>116 Oak Mere Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Greaser</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1900</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Greaser</u>				14. MOTHER'S MAIDEN NAME <u>Elisha Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-24-3035</u>		INFORMANT <u>116 Oak Mere Road</u> <u>Mr. Robert E. Greaser, Owings Mills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cachexia</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-30</u> to <u>4-23-59</u> , that I last saw the deceased alive on <u>4-22-59</u> and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Saffell</u>		M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown Md 4-25-59</u>		DATE SIGNED <u>Reisterstown Md 4-25-59</u>	
PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mays Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lutherville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Lutherville, Md</u>				24a. APR 28 1959 DATE		24b. REGISTERAR'S SIGNATURE <u>Charles E. Hume</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2011-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 ~~22~~
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4008

CERTIFICATE OF DEATH

03987

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>		h. STREET ADDRESS <u>6624 Marrott Drive</u>	
3. NAME OF DECEASED (Type or print) <u>David H. Greene</u> First Middle Last		4. DATE OF DEATH <u>April 16 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Greene</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Freda Marrott - Greene</u>	
17. INFORMANT <u>Freda Marrott - Greene</u> Address <u>- 6624 Marrott Drive</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.S. + Hypertension C.V.D.</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 yrs.</u> <u>15 YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>4/15</u> to <u>4/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>59</u> , and that death occurred at <u>11:40 A</u> M, from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>Baltimore - 23</u>		DATE SIGNED <u>APR 20 '59</u>	
ACTUAL SIGNATURE <u>David E. Board</u> M.D. <u>1905 W. Baltimore</u>		PHYSICIAN'S NAME (Type) <u>D.E. Board, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Har Zion Hebrew Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Rosedale, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Geinson</u> ADDRESS <u>1124 W. North Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4009

CERTIFICATE OF DEATH

03988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 121 South East Ave			
3. NAME OF DECEASED (Type or print) First GEORGE Middle F Last GREENE				4. DATE OF DEATH Month April Day 14 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman				10b. KIND OF BUSINESS OR INDUSTRY Railroad Co		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME George F. Greene				14. MOTHER'S MAIDEN NAME Catherine A Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 399-10-3884		17. INFORMANT Clin. Recs., Veterans Adm. Hospital Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 CARCINOMA, ANAPLASTIC, METASTATIC OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 156.1 DUE TO (c) 156.1							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from March 31, 1959 to April 14, 1959 and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD DATE SIGNED 4/16/59							
ACTUAL SIGNATURE John W. Crawford M.D. VAH FT HOWARD, MD				DATE SIGNED 4/16/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, MD.				DATE SIGNED 4/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc.				ADDRESS 6009 Harford Rd. Balto. Md		24a. REC'D BY REGISTRAR APR 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hens							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1908

CERTIFICATE OF DEATH

1908

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

RECEIVED
BALTIMORE
MAY 10 1908

Name of Deceased		Sex		Age	
John Smith		Male		45	
Date of Death		Place of Death		Cause of Death	
May 10, 1908		Home		Heart Disease	
Time of Death		Occupation		Signature of Physician	
10:00 AM		Carpenter		J. B. Jones	
Signature of Informant		Relationship		Signature of Registrar	
W. H. Smith		Son		J. B. Jones	
Address		City		County	
123 Main St		Baltimore		Baltimore	
State		County		City	
Maryland		Baltimore		Baltimore	
Registration District		Ward		Precinct	
1		1		1	
Signature of Registrar		Signature of Informant		Signature of Physician	
J. B. Jones		W. H. Smith		J. B. Jones	
Date of Registration		Time of Registration		Place of Registration	
May 10, 1908		10:00 AM		Baltimore	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4010

CERTIFICATE OF DEATH

03989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3301 Chapman Road</u>		d. STREET ADDRESS <u>3301 Chapman Road</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick A. Greenwalt</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Randallstown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Greenwalt</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Frank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-05-4253</u>	
17. INFORMANT <u>Mrs. Bertha Greenwalt</u>		Address <u>3301 Chapman Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Pulmonary Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis of Brachial Artery</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-23</u> , 19 <u>59</u> to <u>4-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-6</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin J. Feldman</u>		ADDRESS (Street, city or town, state) <u>1 Cherry Hill Rd. Reisterstown, Md</u>	
PHYSICIAN'S NAME (Type) <u>Martin J. Feldman</u>		DATE SIGNED <u>4/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Int. Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road</u>	
24a. RECEIVED BY REGISTRAR DATE <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

85322

See Rev. 1-1-57

1. Name of deceased (Print or write full name)
Name

Sex

Date of birth

2. Date of death (Month, day, year)
Date

Place

Time

3. Cause of death (List all causes, beginning with the immediate cause)
Cause

Place

Time

4. Nature of disease or injury (List all diseases or injuries, beginning with the immediate cause)
Cause

Place

Time

5. Name of physician (Print or write full name)
Name

Address

City

6. Name of medical examiner (Print or write full name)
Name

Address

City

7. Name of funeral home (Print or write full name)
Name

Address

City

8. Name of hospital (Print or write full name)
Name

Address

City

9. Name of coroner (Print or write full name)
Name

Address

City

10. Name of registrar (Print or write full name)
Name

Address

City

11. Name of informant (Print or write full name)
Name

Address

City

12. Name of witness (Print or write full name)
Name

Address

City

13. Name of informant (Print or write full name)
Name

Address

City

14. Name of witness (Print or write full name)
Name

Address

City

15. Name of informant (Print or write full name)
Name

Address

City

16. Name of witness (Print or write full name)
Name

Address

City

17. Name of informant (Print or write full name)
Name

Address

City

18. Name of witness (Print or write full name)
Name

Address

City

19. Name of informant (Print or write full name)
Name

Address

City

20. Name of witness (Print or write full name)
Name

Address

City

21. Name of informant (Print or write full name)
Name

Address

City

22. Name of witness (Print or write full name)
Name

Address

City

23. Name of informant (Print or write full name)
Name

Address

City

MARYLAND

STATE DEPARTMENT OF HEALTH

3937 CERTIFICATE OF DEATH

Reg. Dist. No. 03990

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highlands</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North Linthicum</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2816 New York Ave.</u>		STREET ADDRESS (If rural, give location) <u>208 Devon Court</u>	
3. NAME OF DECEASED (First) <u>MARIE</u> (Middle) <u>L.</u> (Last) <u>GUERKE</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1959</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>July 21, 1889</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - rtd</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>--</u>	
13. FATHER'S NAME <u>Eli H. Kahline</u>		14. MOTHER'S MAIDEN NAME <u>Mary -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mr. Francis G. Guerke - 208 Devon Court</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>420.1 Coronary Thrombosis</u>			<u>1 day</u>
(b) Antecedent cause(s) <u>Hypertension C.U.D.</u>			<u>3 years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2, 1959</u> to <u>April 25, 1959</u> , that I last saw the deceased alive on <u>April 25, 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul Seinfeld</u> (Degree or title)		ADDRESS <u>2501 Arden Rd</u> DATE SIGNED <u>4/29/59</u>	
23. BURIAL-CREATION REMOVAL (Specify) <u>Burial</u>		DATE <u>5/2/59</u>	
NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REG <u>MAY 1 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Renshaw</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Vickers & Sons</u>		ADDRESS <u>Balto 17th</u>	

MARGIN RESERVED FOR BINDING

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR

1899

ALBANY:

WILEY & SONS

PRINTERS

1900

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR

1899

ALBANY:

WILEY & SONS

PRINTERS

1900

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4011

CERTIFICATE OF DEATH

03991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 3522 Virginia Ave.	
3. NAME OF DECEASED (Type or print) First ANGELINE Middle BLANCHE Last GUISE		4. DATE OF DEATH Month April Day 13 , Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Iowa	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward J. Bodie		14. MOTHER'S MAIDEN NAME May Stockwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Vernon Barber - 3522 Virginia Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Coronary atherosclerosis DUE TO (c) Cardiovascular failure			INTERVAL BETWEEN ONSET AND DEATH 3 hrs - intra
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26 , 19 59 , to April 13 , 19 59 , that I last saw the deceased alive on 4/6 , 19 59 , and that death occurred at 4:45 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cliff Ratliff		ADDRESS (Street, city or town, state) 4605 Edmondson Rd. Baltimore 29, Md.	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, M.D.		DATE SIGNED 4/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4/14/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	22d. LOCATION (City, town, or county) (State) Camanche, Iowa
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - 1600 17th		24a. REC'D BY REGISTRAR DATE APR 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Brown			

CERTIFICATE OF DEATH

DATE

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitary inspector	
28. Signature of food inspector		29. Signature of milk inspector		30. Signature of water inspector	
31. Signature of sewage inspector		32. Signature of waste inspector		33. Signature of air inspector	
34. Signature of noise inspector		35. Signature of radiation inspector		36. Signature of other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

03992

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forge Road				d. STREET ADDRESS Forge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First H. Middle Louise Last Gwynn				4. DATE OF DEATH Month April Day 4 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-13-1881	
9. AGE (In years last birthday) 77 7/8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Nelson				14. MOTHER'S MAIDEN NAME Frances C. Derrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lewis Gwynn Address Forge Road Fullerton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from stomach & Esophagus 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophic Arthritis (poly)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 yrs.	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1949 to 4/4, 1959 , that I last saw the deceased alive at 4/4, 1959 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE CLIFFORD F. HUDSON M.D.				ADDRESS (Street, city or town, state) FORK, MD.			
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON				DATE SIGNED FORK, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-59		22c. NAME OF CEMETERY OR CREMATORY Mount Zion		22d. LOCATION (City, town, or county) (State) Longgreen, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Francis A. Heavley				ADDRESS 578 W. Biddle St		24a. REC'D BY REGISTRAR DATE APR 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4013

Items 13, 14 Film G242 5-6-59 et

CERTIFICATE OF DEATH

03993
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7160 Gough St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle J. Last HAMMER				4. DATE OF DEATH Month April Day 18 Year 19 59.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1898.	
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 3 Days 15 Hours 15 Min.		11. IF UNDER 24 HRS. Months 3 Days 15 Hours 15 Min.		12. IF UNDER 24 HRS. Months 3 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Amer. Smelt. & Ref.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Hammer				14. MOTHER'S MAIDEN NAME Louise Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Madeline B. Hammer				Address Same.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma involving the entire oral cavity DUE TO 160.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous cell carcinoma left antrum DUE TO 15 months (c) 15 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 23, 19 58 to present , 19 59 , that I last saw the deceased alive on April 16, 19 59 , and that death occurred at 6 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 E. Biddle Street DATE SIGNED 20 Apr 59 ACTUAL SIGNATURE Arthur G. Siwinski M.D. PHYSICIAN'S NAME (Type) Arthur G. Siwinski Baltimore -2, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 4-21 59.			
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery				22d. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Geeler 9015 CONKLIN ST. BALTO 24, MD.				24a. REC'D BY REGISTRAR DATE APR 21 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas							

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OFFICE OF THE SECRETARY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4014
CERTIFICATE OF DEATH

03994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 7 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard & Enoch Pratt Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dora</u> <u>Waring</u> <u>Hatch</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>11</u> <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 20, 1882</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank I Duncan</u>		14. MOTHER'S MAIDEN NAME <u>Clara Evenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ernest C. Hatch</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>15+ yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12, 1956</u> to <u>April 11, 1959</u> , that I last saw the deceased alive on <u>April 11, 1959</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard J. Epstein</u> M.D.		ADDRESS (Street, city or town, state) <u>April 11, 1959</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Leonard J. Epstein, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4015

CERTIFICATE OF DEATH

03995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>10 mos 15 dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elmer Benson Hobbs</u>		4. DATE OF DEATH <u>April 11 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self emp.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Hobbs</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Records Spring Grove State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarctive myocardial fibrosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years/dys</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 17, 1959</u> , to <u>April 11, 1959</u> , that I last saw the deceased alive on <u>April 11, 1959</u> , and that death occurred at <u>3:50 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hospital</u> DATE SIGNED <u>4/12/59</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		<u>Catonsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Johnson & Son</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE HEALTH DEPARTMENT
STATE OF CALIFORNIA

DEATH CERTIFICATE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BATHING
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH MEMPHIS, TENNESSEE	
7. CAUSE OF DEATH MURDER		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH MOBILE, ALABAMA	
10. OCCUPATION None		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS MEDICATION None		20. PREVIOUS VACCINATIONS None		21. PREVIOUS TRANSFUSIONS None	
22. PREVIOUS ORGANS None		23. PREVIOUS TISSUES None		24. PREVIOUS CELLS None	
25. PREVIOUS BLOOD None		26. PREVIOUS SPERM None		27. PREVIOUS OVUM None	
28. PREVIOUS EMBRYO None		29. PREVIOUS FETUS None		30. PREVIOUS PLACENTA None	
31. PREVIOUS CORD None		32. PREVIOUS MEMBRANE None		33. PREVIOUS AMNION None	
34. PREVIOUS PERITONEUM None		35. PREVIOUS Vagina None		36. PREVIOUS UTERUS None	
37. PREVIOUS Ovary None		38. PREVIOUS Fallopian None		39. PREVIOUS Cervix None	
40. PREVIOUS Vagina None		41. PREVIOUS Uterus None		42. PREVIOUS Ovary None	
43. PREVIOUS Fallopian None		44. PREVIOUS Cervix None		45. PREVIOUS Vagina None	
46. PREVIOUS Uterus None		47. PREVIOUS Ovary None		48. PREVIOUS Fallopian None	
49. PREVIOUS Cervix None		50. PREVIOUS Vagina None		51. PREVIOUS Uterus None	
52. PREVIOUS Ovary None		53. PREVIOUS Fallopian None		54. PREVIOUS Cervix None	
55. PREVIOUS Vagina None		56. PREVIOUS Uterus None		57. PREVIOUS Ovary None	
58. PREVIOUS Fallopian None		59. PREVIOUS Cervix None		60. PREVIOUS Vagina None	
61. PREVIOUS Uterus None		62. PREVIOUS Ovary None		63. PREVIOUS Fallopian None	
64. PREVIOUS Cervix None		65. PREVIOUS Vagina None		66. PREVIOUS Uterus None	
67. PREVIOUS Ovary None		68. PREVIOUS Fallopian None		69. PREVIOUS Cervix None	
70. PREVIOUS Vagina None		71. PREVIOUS Uterus None		72. PREVIOUS Ovary None	
73. PREVIOUS Fallopian None		74. PREVIOUS Cervix None		75. PREVIOUS Vagina None	
76. PREVIOUS Uterus None		77. PREVIOUS Ovary None		78. PREVIOUS Fallopian None	
79. PREVIOUS Cervix None		80. PREVIOUS Vagina None		81. PREVIOUS Uterus None	
82. PREVIOUS Ovary None		83. PREVIOUS Fallopian None		84. PREVIOUS Cervix None	
85. PREVIOUS Vagina None		86. PREVIOUS Uterus None		87. PREVIOUS Ovary None	
88. PREVIOUS Fallopian None		89. PREVIOUS Cervix None		90. PREVIOUS Vagina None	
91. PREVIOUS Uterus None		92. PREVIOUS Ovary None		93. PREVIOUS Fallopian None	
94. PREVIOUS Cervix None		95. PREVIOUS Vagina None		96. PREVIOUS Uterus None	
97. PREVIOUS Ovary None		98. PREVIOUS Fallopian None		99. PREVIOUS Cervix None	
100. PREVIOUS Vagina None		101. PREVIOUS Uterus None		102. PREVIOUS Ovary None	
103. PREVIOUS Fallopian None		104. PREVIOUS Cervix None		105. PREVIOUS Vagina None	
106. PREVIOUS Uterus None		107. PREVIOUS Ovary None		108. PREVIOUS Fallopian None	
109. PREVIOUS Cervix None		110. PREVIOUS Vagina None		111. PREVIOUS Uterus None	
112. PREVIOUS Ovary None		113. PREVIOUS Fallopian None		114. PREVIOUS Cervix None	
115. PREVIOUS Vagina None		116. PREVIOUS Uterus None		117. PREVIOUS Ovary None	
118. PREVIOUS Fallopian None		119. PREVIOUS Cervix None		120. PREVIOUS Vagina None	
121. PREVIOUS Uterus None		122. PREVIOUS Ovary None		123. PREVIOUS Fallopian None	
124. PREVIOUS Cervix None		125. PREVIOUS Vagina None		126. PREVIOUS Uterus None	
127. PREVIOUS Ovary None		128. PREVIOUS Fallopian None		129. PREVIOUS Cervix None	
130. PREVIOUS Vagina None		131. PREVIOUS Uterus None		132. PREVIOUS Ovary None	
133. PREVIOUS Fallopian None		134. PREVIOUS Cervix None		135. PREVIOUS Vagina None	
136. PREVIOUS Uterus None		137. PREVIOUS Ovary None		138. PREVIOUS Fallopian None	
139. PREVIOUS Cervix None		140. PREVIOUS Vagina None		141. PREVIOUS Uterus None	
142. PREVIOUS Ovary None		143. PREVIOUS Fallopian None		144. PREVIOUS Cervix None	
145. PREVIOUS Vagina None		146. PREVIOUS Uterus None		147. PREVIOUS Ovary None	
148. PREVIOUS Fallopian None		149. PREVIOUS Cervix None		150. PREVIOUS Vagina None	
151. PREVIOUS Uterus None		152. PREVIOUS Ovary None		153. PREVIOUS Fallopian None	
154. PREVIOUS Cervix None		155. PREVIOUS Vagina None		156. PREVIOUS Uterus None	
157. PREVIOUS Ovary None		158. PREVIOUS Fallopian None		159. PREVIOUS Cervix None	
160. PREVIOUS Vagina None		161. PREVIOUS Uterus None		162. PREVIOUS Ovary None	
163. PREVIOUS Fallopian None		164. PREVIOUS Cervix None		165. PREVIOUS Vagina None	
166. PREVIOUS Uterus None		167. PREVIOUS Ovary None		168. PREVIOUS Fallopian None	
169. PREVIOUS Cervix None		170. PREVIOUS Vagina None		171. PREVIOUS Uterus None	
172. PREVIOUS Ovary None		173. PREVIOUS Fallopian None		174. PREVIOUS Cervix None	
175. PREVIOUS Vagina None		176. PREVIOUS Uterus None		177. PREVIOUS Ovary None	
178. PREVIOUS Fallopian None		179. PREVIOUS Cervix None		180. PREVIOUS Vagina None	
181. PREVIOUS Uterus None		182. PREVIOUS Ovary None		183. PREVIOUS Fallopian None	
184. PREVIOUS Cervix None		185. PREVIOUS Vagina None		186. PREVIOUS Uterus None	
187. PREVIOUS Ovary None		188. PREVIOUS Fallopian None		189. PREVIOUS Cervix None	
190. PREVIOUS Vagina None		191. PREVIOUS Uterus None		192. PREVIOUS Ovary None	
193. PREVIOUS Fallopian None		194. PREVIOUS Cervix None		195. PREVIOUS Vagina None	
196. PREVIOUS Uterus None		197. PREVIOUS Ovary None		198. PREVIOUS Fallopian None	
199. PREVIOUS Cervix None		200. PREVIOUS Vagina None		201. PREVIOUS Uterus None	
202. PREVIOUS Ovary None		203. PREVIOUS Fallopian None		204. PREVIOUS Cervix None	
205. PREVIOUS Vagina None		206. PREVIOUS Uterus None		207. PREVIOUS Ovary None	
208. PREVIOUS Fallopian None		209. PREVIOUS Cervix None		210. PREVIOUS Vagina None	
211. PREVIOUS Uterus None		212. PREVIOUS Ovary None		213. PREVIOUS Fallopian None	
214. PREVIOUS Cervix None		215. PREVIOUS Vagina None		216. PREVIOUS Uterus None	
217. PREVIOUS Ovary None		218. PREVIOUS Fallopian None		219. PREVIOUS Cervix None	
220. PREVIOUS Vagina None		221. PREVIOUS Uterus None		222. PREVIOUS Ovary None	
223. PREVIOUS Fallopian None		224. PREVIOUS Cervix None		225. PREVIOUS Vagina None	
226. PREVIOUS Uterus None		227. PREVIOUS Ovary None		228. PREVIOUS Fallopian None	
229. PREVIOUS Cervix None		230. PREVIOUS Vagina None		231. PREVIOUS Uterus None	
232. PREVIOUS Ovary None		233. PREVIOUS Fallopian None		234. PREVIOUS Cervix None	
235. PREVIOUS Vagina None		236. PREVIOUS Uterus None		237. PREVIOUS Ovary None	
238. PREVIOUS Fallopian None		239. PREVIOUS Cervix None		240. PREVIOUS Vagina None	
241. PREVIOUS Uterus None		242. PREVIOUS Ovary None		243. PREVIOUS Fallopian None	
244. PREVIOUS Cervix None		245. PREVIOUS Vagina None		246. PREVIOUS Uterus None	
247. PREVIOUS Ovary None		248. PREVIOUS Fallopian None		249. PREVIOUS Cervix None	
250. PREVIOUS Vagina None		251. PREVIOUS Uterus None		252. PREVIOUS Ovary None	
253. PREVIOUS Fallopian None		254. PREVIOUS Cervix None		255. PREVIOUS Vagina None	
256. PREVIOUS Uterus None		257. PREVIOUS Ovary None		258. PREVIOUS Fallopian None	
259. PREVIOUS Cervix None		260. PREVIOUS Vagina None		261. PREVIOUS Uterus None	
262. PREVIOUS Ovary None		263. PREVIOUS Fallopian None		264. PREVIOUS Cervix None	
265. PREVIOUS Vagina None		266. PREVIOUS Uterus None		267. PREVIOUS Ovary None	
268. PREVIOUS Fallopian None		269. PREVIOUS Cervix None		270. PREVIOUS Vagina None	
271. PREVIOUS Uterus None		272. PREVIOUS Ovary None		273. PREVIOUS Fallopian None	
274. PREVIOUS Cervix None		275. PREVIOUS Vagina None		276. PREVIOUS Uterus None	
277. PREVIOUS Ovary None		278. PREVIOUS Fallopian None		279. PREVIOUS Cervix None	
280. PREVIOUS Vagina None		281. PREVIOUS Uterus None		282. PREVIOUS Ovary None	
283. PREVIOUS Fallopian None		284. PREVIOUS Cervix None		285. PREVIOUS Vagina None	
286. PREVIOUS Uterus None		287. PREVIOUS Ovary None		288. PREVIOUS Fallopian None	
289. PREVIOUS Cervix None		290. PREVIOUS Vagina None		291. PREVIOUS Uterus None	
292. PREVIOUS Ovary None		293. PREVIOUS Fallopian None		294. PREVIOUS Cervix None	
295. PREVIOUS Vagina None		296. PREVIOUS Uterus None		297. PREVIOUS Ovary None	
298. PREVIOUS Fallopian None		299. PREVIOUS Cervix None		300. PREVIOUS Vagina None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4016

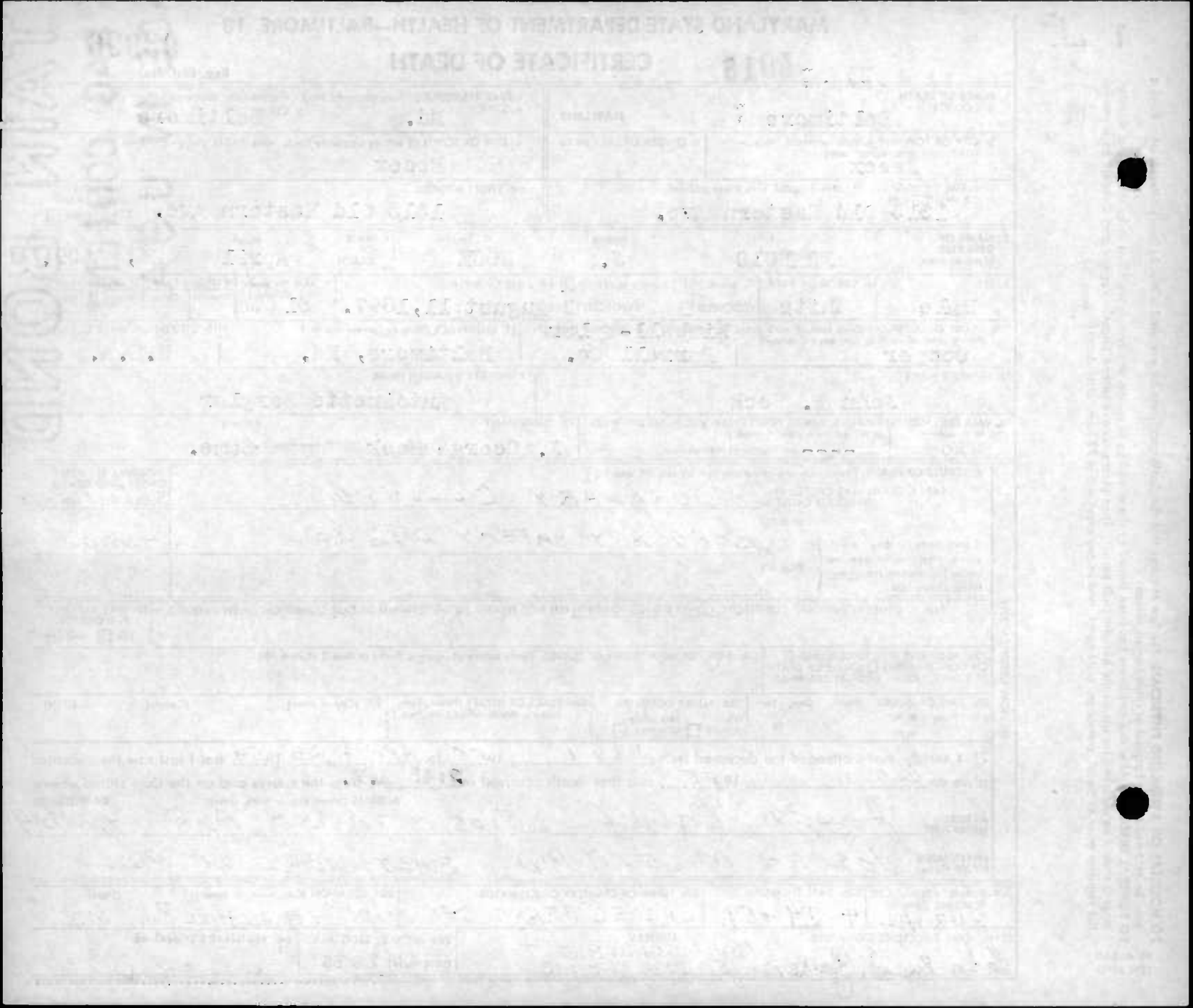
CERTIFICATE OF DEATH

03996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN lb 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1213 Old Eastern Ave.		d. STREET ADDRESS 1313 Old Eastern Ave.	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle J. Last HOCK		4. DATE OF DEATH Month April Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1897.
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John F. Hock	
14. MOTHER'S MAIDEN NAME Antoinette Bergler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----	
16. SOCIAL SECURITY NO. ----		17. INFORMANT J. George Hock Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c) 9 mo.			INTERVAL BETWEEN ONSET AND DEATH SUPPER DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 1 , 19 58 , to APRIL 26 , 19 59 , that I last saw the deceased alive on OCT. 31 , 19 58 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE DATE SIGNED 4/28/59	
PHYSICIAN'S NAME (Type) JOSEPH MICELI MD.		BALTIMORE 21 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-29-59	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 1401 GERMAN HILL RD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Geiler		ADDRESS 901 S. CONKLING ST. BALTO., 21, MD.	
24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Charles L. Geiler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Brookside Rd.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 205 Brookside Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Frederick Holmes		4. DATE OF DEATH April 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1916
9. AGE (In years last birthday) 42 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Good Humor Co.	
11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Hughes		14. MOTHER'S MAIDEN NAME Julia Y Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1-11-11	
17. INFORMANT Mrs. Rosa M. Holmes		Address 205 Brookside Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Coronary thrombosis. DUE TO Cirrhosis of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-59	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) Balto. (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Julius Funeral Home Catonsville Md		24a. REC'D BY REGISTRAR MAY 5 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4018

CERTIFICATE OF DEATH

Reg. Dist. No.

03998

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md				c. LENGTH OF STAY IN 1b 57 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle W Last HOOT				4. DATE OF DEATH Month April Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 20, 1926	
9. AGE (In years last birthday) 33 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Carl F. Hoot				14. MOTHER'S MAIDEN NAME Elizabeth Baer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 218-16-1666		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACROMEGALOGIGANTISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 5, 1959 , to April 3, 1959 , and that death occurred at 6:30 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD DATE SIGNED 4/3/59 ACTUAL SIGNATURE John W. Crawford M.D. JOHN W. CRAWFORD, M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		22d. LOCATION (City, town, or county) (State) Balto. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Heights, Balto. Md		24a. REC'D BY REGISTRAR APR 9 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
BOSTON
CERTIFICATE OF DEATH

BOSTON

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Time of Certificate		Place of Certificate	
Name of Registrar		Name of Coroner		Name of Physician	
Address of Registrar		Address of Coroner		Address of Physician	
City of Registrar		City of Coroner		City of Physician	
State of Registrar		State of Coroner		State of Physician	
Country of Registrar		Country of Coroner		Country of Physician	
Signature of Deceased		Signature of Next of Kin		Signature of Witness	
Date of Signature		Time of Signature		Place of Signature	
Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Time of Certificate		Place of Certificate	
Name of Registrar		Name of Coroner		Name of Physician	
Address of Registrar		Address of Coroner		Address of Physician	
City of Registrar		City of Coroner		City of Physician	
State of Registrar		State of Coroner		State of Physician	
Country of Registrar		Country of Coroner		Country of Physician	
Signature of Deceased		Signature of Next of Kin		Signature of Witness	
Date of Signature		Time of Signature		Place of Signature	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4019 **CERTIFICATE OF DEATH** **Item 9 Film G241 4-20-59 at** **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

03999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 191 Othoridge Rd.		d. STREET ADDRESS 151 Othoridge Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last HOPKINS		4. DATE OF DEATH Month April Day 10 Year 1959	
5. SEX Malr	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH J, ne 15, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hopkins		14. MOTHER'S MAIDEN NAME Ellen Chaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Estelle B. Hopkins		Address 151 Othoridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Heart Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 3 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1957 , to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE WM. G. GEYER		DATE SIGNED 156 N. Weston Ave. Baltimore, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/59	
22c. NAME OF CEMETERY OR CREMATORY Smithland		22d. LOCATION (City, town, or county) (State) Rainswood, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		24a. REC'D BY REGISTRAR DATE APR 13 '59	
ADDRESS 1050 York Rd. Towson		24b. REGISTRAR'S SIGNATURE William L. Hume	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES JOHNSON		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE Jan 1, 1915		6. BIRTH PLACE Baltimore, Md.	
7. DEATH DATE Dec 1, 1960		8. DEATH PLACE Baltimore, Md.		9. CAUSE OF DEATH Heart Disease	
10. SIGNATURE OF DECEASED James Johnson		11. SIGNATURE OF WITNESS John Doe		12. SIGNATURE OF PHYSICIAN Dr. Smith	
13. SIGNATURE OF REGISTRAR John Doe		14. SIGNATURE OF CLERK Jane Smith		15. SIGNATURE OF NOTARY Notary Public	

1. I, the undersigned, being a duly qualified and sworn health officer, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named herein, as the same appears from the records of the Department of Health, State of Maryland.

2. I, the undersigned, being a duly qualified and sworn health officer, do hereby certify that the foregoing is a true and correct copy of the original record of the death of the person named herein, as the same appears from the records of the Department of Health, State of Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4020

CERTIFICATE OF DEATH

Reg. Dist. No. 04000

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6yr2mthldy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Francis Last Horman		4. DATE OF DEATH Month April Day 1 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1912
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Welsh Horman		14. MOTHER'S MAIDEN NAME Edna Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216-14-7676	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 1959 , to April 1, 1959 , that I last saw the deceased alive on April 1, 1959 , and that death occurred at 9:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-2-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount View Cem.		22d. LOCATION (City, town, or county) (State) Howard County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Triantafyllou		ADDRESS 3512 Frederick Ave.	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4021

CERTIFICATE OF DEATH

04001

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuba, Rd.</u>				d. STREET ADDRESS <u>Cuba Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>H.</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 26, 1946</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ORLANDO HOWARD</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR MADDEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ORLANDO HOWARD</u> Address <u>COCKEYSVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis - chronic</u> DUE TO <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>poor</u> DUE TO <u>poor</u> (c) <u>poor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>poor</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-59</u> to <u>4-1-59</u> , that I last saw the deceased alive on <u>3-31-59</u> 19 <u>59</u> and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Saffell</u> M.D.				DATE SIGNED <u>4-2-59</u>			
PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>				ADDRESS (Street, City or town, State) <u>Reisterstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Schatzman</u>				ADDRESS <u>1701 W. Calhoun</u>		24a. REC'D BY REGISTRAR <u>APR 6 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4022

CERTIFICATE OF DEATH

Reg. Dist. No. 04002

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				d. STREET ADDRESS <u>Stone Chapel Lane</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Major Stephen Harrison Howard</u>				4. DATE OF DEATH Month Day Year <u>April 27 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14/1884</u>	
9. AGE (In years last birthday) <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Major U.S.M.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>General Roberts Md. 48</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Ellen Spencer Howard</u>			
14. MOTHER'S MAIDEN NAME <u>Emmie B. Loughart</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>312-09-1756A</u> 17. INFORMANT <u>Mr Josephine P. Howard - Pikesville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X upper respiratory infection</u> DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(arterio-sclerotic) auricular fibrillation</u> DUE TO <u>10 days</u> <u>18 months</u> <u>1 1/2 months</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 4</u> , 19 <u>36</u> to <u>April 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 26</u> , 19 <u>59</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Pikesville 8 - Md.</u>			
DATE SIGNED <u>4/27/59</u>							
PHYSICIAN'S NAME (Type) <u>PALMER F. C. Williams</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Apr 29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Leesburg - Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Menden</u> ADDRESS <u>108 W 7th - Balt</u>				24. REC'D BY REGISTRAR DATE <u>MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3926 Items 1 5 6 7 Film G242.5-8-59 md

CERTIFICATE OF DEATH

04003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>53 Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>				d. STREET ADDRESS <u>119 Ventnor Ter</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Edgerton Hughes</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18 1940</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Conductor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Belt Steel</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
13. FATHER'S NAME <u>Wade E. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Maudie Edgerton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>089-45-2318</u>			
17. INFORMANT <u>Mary M. Hughes</u>				Address <u>119 Ventnor Ter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Left Lung a</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Brain, Skull etc</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>April 10</u> to <u>April 30</u> , 19 <u>59</u> , that I lost sow the deceased alive on <u>April 10</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Davis</u>				ADDRESS (Street, city or town, state) <u>6800 Morning Star</u>			
PHYSICIAN'S NAME (Type) <u>M. B. Davis MD</u>				DATE SIGNED <u>4/30/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 25 59</u>				22b. DATE THEREOF <u>May 25 59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Horn</u>				ADDRESS <u>2112 Dundalk</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneib</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The following is a list of the
 names of the persons who
 have been appointed to the
 various committees of the
 Board of Directors of the
 City of New York, for the
 year 1900.

The following is a list of the
 names of the persons who
 have been appointed to the
 various committees of the
 Board of Directors of the
 City of New York, for the
 year 1900.

4023

CERTIFICATE OF DEATH

04004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN lb 3 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hobb Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Waterbury c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waterbury d. STREET ADDRESS 45X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First A. Hughes Middle Last		4. DATE OF DEATH 4-11-59 Month Day Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) Birmingham, England
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Smith	
14. MOTHER'S MAIDEN NAME Sally Lunn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. U		INFORMANT Address Mrs. Ethel M. Kyper, 827 Park Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral vascular accident at hemiplegia DUE TO (b) generalized arteriosclerosis DUE TO (c) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 10 , 19 59 , to Apr 11 , 19 59 , that I last saw the deceased alive on 10 Apr , 19 59 , and that death occurred at 8:57 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul H Royse		ADDRESS (Street, city or town, state) 808 Beisterstown Rd DATE SIGNED 11 Apr 59	
PHYSICIAN'S NAME (Type) Paul H Royse MD		Pikesville 8 md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-15-59	22b. DATE THEREOF Burial	22c. NAME OF CEMETERY OR CREMATORY Pine Grove	22d. LOCATION (City, town, or county) (State) Waterbury Conn.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR Pikesville 8 md.	
24b. REGISTRAR'S SIGNATURE Carroll S. Hous		DATE APR 13 '59	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

23020

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4024

CERTIFICATE OF DEATH

Reg. Dist. No.

04005

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olivet 04X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) (Jennie) ALICE VIRGINIA First Middle Lost		4. DATE OF DEATH April Month 20 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 7, 1870 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Jay		14. MOTHER'S MAIDEN NAME Henrietta F. PARKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1 , 19 58 , to April 20 , 19 59 , that I last saw the deceased alive on April 19 , 19 59 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James Donald Drinkard		ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4-20-59	
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.		Catonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APR. 22, 1959	22c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) CALVERT CO. MD
23. FUNERAL DIRECTOR'S SIGNATURE Harkness Funeral Home		ADDRESS M.D.	24a. REC'D BY REGISTRAR APR 22 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>10-25-1965</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Usual residence: <u>1234 E. MAIN ST. BALTIMORE, MD</u></p>		<p>8. Cause of death: <u>HEART DISEASE</u></p>	
<p>9. Immediate cause: <u>MYOCARDIAL INFARCTION</u></p>		<p>10. Underlying cause: <u>ATHEROSCLEROSIS</u></p>	
<p>11. Contributing cause: <u>HYPERTENSION</u></p>		<p>12. Manner of death: <u>NATURAL</u></p>	
<p>13. Physician's signature: <u>DR. J. H. BROWN</u></p>		<p>14. Registrar's signature: <u>JOHN D. WHITE</u></p>	
<p>15. Date of registration: <u>10-26-1965</u></p>		<p>16. Place of registration: <u>BALTIMORE</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4025

CERTIFICATE OF DEATH

04006
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHEARN</u>		c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>A</u> Last <u>LENNOCK</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 3, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Blenheim MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Geo Trapp</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA BURK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records</u>		Address <u>6811 Campfield Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/26</u> , 19 <u>53</u> , to <u>4/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>59</u> , and that death occurred at <u>30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		DATE SIGNED <u>4-8-59</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		22d. LOCATION (City, town, or county) (State) <u>JACKSONVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.A. Heemann</u>		ADDRESS <u>6067 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9802 Hilltop Drive</i>		e. STREET ADDRESS <i>9802 Hilltop Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Roy L. Jenkins</i>		4. DATE OF DEATH <i>April 5th 19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 20, 1899</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Co. Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John W. Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Kl iningham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-03-8374</i>	
17. INFORMANT <i>Mrs. Gerturde L. Jenkins,</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1945</i> to <i>April 5, 1959</i> , that I last saw the deceased alive on <i>April 4, 1959</i> , and that death occurred at <i>7:45 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. M. Bacon</i> M.D.		ADDRESS (Street, city or town, state) <i>2810 Taylor Ave</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/9/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road</i>		24a. REC'D BY REGISTRAR DATE <i>APR 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Perna</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4027

CERTIFICATE OF DEATH

04008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mths16dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4217 Flowerton Road	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Clare Jerome		4. DATE OF DEATH Month Day Year April 9 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleslady		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Chauncey Jerome		14. MOTHER'S MAIDEN NAME Anna Flock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterioclrosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgical treatment for frac. rt. femur in Nov. 1958			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22 , 19 58 , to 4-9 , 19 59 , that I last saw the deceased alive on 4-9 , 19 59 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
DATE SIGNED 4-9-59		M.D.	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11/59	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fitzke Funeral Directors, 4101 E. Madison Ave.		24a. REC'D BY REGISTRAR APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howe			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4028

CERTIFICATE OF DEATH

04009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr20dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>314 Stafford Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Calb</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records</u>		Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>59</u> , to <u>April 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>59</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4/11/1959</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earley Funeral Home - Catonsville, Md.</u>		ADDRESS <u>Catonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

LAST NAME		FIRST NAME		MIDDLE NAME	
JAMES		JOHN		BUTLER	
AGE		SEX		RACE	
65		Male		White	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
1843		New York		New York	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
1908		New York		New York	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
Heart Failure		Natural		Coronary Artery Disease	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
1908		New York		New York	
NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF FUNERAL HOME	
Rev. Mr. Smith		Rev. Mr. Jones		Mr. Brown	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY	
Mr. Brown		St. John's		St. John's	
NAME OF WITNESSES		NAME OF WITNESSES		NAME OF WITNESSES	
John Doe		Jane Smith		Robert Johnson	
NAME OF REGISTRAR		NAME OF REGISTRAR		NAME OF REGISTRAR	
John Doe		Jane Smith		Robert Johnson	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
RECEIVED
JAN 1 1908
JAMES JOHN BUTLER
65
1843
1908
Heart Failure
Natural
Coronary Artery Disease
1908
New York
New York
New York
Rev. Mr. Smith
Rev. Mr. Jones
Mr. Brown
Mr. Brown
St. John's
St. John's
John Doe
Jane Smith
Robert Johnson
John Doe
Jane Smith
Robert Johnson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4029

CERTIFICATE OF DEATH

04010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 9 N. Bond Street	
3. NAME OF DECEASED (Type or print) First SHOVINE Middle Last JOHNSON		4. DATE OF DEATH Month April Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1931
9. AGE (In years lost birthday) yrs. 28		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Cutter		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill	
11. BIRTHPLACE (State or foreign country) Manning, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Johnson		14. MOTHER'S MAIDEN NAME ALICE WAITERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes PL-28		16. SOCIAL SECURITY NO. Clinical Records, VA Hosp., Ft. Howard, Md.	
17. INFORMANT Clinical Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS ASTHMATICUS DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 23, 1959 , to April 25, 1959 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MD. 4/25/59			
ACTUAL SIGNATURE Rolando D. Ponce de Leon		PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/29/1959	22c. NAME OF CEMETERY OR CREMATORY Society Hill AME Church Cemetery
22d. LOCATION (City, town, or county) (State) Manning, South Carolina		23. FUNERAL DIRECTOR'S SIGNATURE ARLINGTON S. PHILLIPS FUNERAL HOME	
24a. REC'D BY REGISTRAR APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

SHIPPED TO: FLEMING FUNERAL HOME, MANNING, SOUTH CAROLINA
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

994

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4030

CERTIFICATE OF DEATH

04011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN TB <u>11 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>620 DUNKIRK Rd</u>		d. STREET ADDRESS <u>620 DUNKIRK Rd</u>	
3. NAME OF DECEASED (Type or print) <u>William Johnson</u>		4. DATE OF DEATH <u>APRIL 23 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1865</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>OSCAR Johnson</u>		14. MOTHER'S MAIDEN NAME <u>MARIAN Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Austin Johnson</u>		Address <u>620 DUNKIRK Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V.D. &</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4-20</u> , 19 <u>40</u> , to <u>4-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-20</u> , 19 <u>59</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Laurence J. Flumanch, M.D.</u> <u>4-27-59</u> PHYSICIAN'S NAME (Type) <u>Laurence J. Flumanch</u> <u>3711 Fall Rd Balt 11 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen F. Seitz</u>		ADDRESS <u>5209 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4031

CERTIFICATE OF DEATH

04012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Olmstead Rd., Pikesville</u>		d. STREET ADDRESS <u>808 Olmstead Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Paul Kelley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A&P Bakery</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Louis Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Muhl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lela Boyle Kelley</u>		Address <u>Pikesville 8, Md.</u> <u>808 Olmstead Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Coronary Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5-6 Hours</u> <u>5 yrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1953</u> to <u>April 26th 1959</u> , that I last saw the deceased alive on <u>April 26th 1959</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Miller Jr.</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd.</u>	
PHYSICIAN'S NAME (Type) <u>James H. Miller M.D.</u>		DATE SIGNED <u>4/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 29, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1037

Wm. Brown

Age 45

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of informant

13. Signature of informant

14. Signature of physician

15. Signature of funeral director

16. Signature of registrar

17. Signature of health officer

18. Signature of coroner

19. Signature of justice of the peace

20. Signature of clerk

21. Signature of recorder

22. Signature of auditor

23. Signature of treasurer

24. Signature of assessor

25. Signature of collector

26. Signature of comptroller

27. Signature of clerk of the court

28. Signature of sheriff

29. Signature of coroner

30. Signature of justice of the peace

31. Signature of clerk

32. Signature of recorder

33. Signature of auditor

34. Signature of treasurer

35. Signature of assessor

36. Signature of collector

37. Signature of comptroller

38. Signature of clerk of the court

39. Signature of sheriff

40. Signature of coroner

41. Signature of justice of the peace

42. Signature of clerk

43. Signature of recorder

44. Signature of auditor

45. Signature of treasurer

46. Signature of assessor

47. Signature of collector

48. Signature of comptroller

49. Signature of clerk of the court

50. Signature of sheriff

51. Signature of coroner

52. Signature of justice of the peace

53. Signature of clerk

54. Signature of recorder

55. Signature of auditor

56. Signature of treasurer

57. Signature of assessor

58. Signature of collector

59. Signature of comptroller

60. Signature of clerk of the court

61. Signature of sheriff

62. Signature of coroner

63. Signature of justice of the peace

64. Signature of clerk

65. Signature of recorder

66. Signature of auditor

67. Signature of treasurer

68. Signature of assessor

69. Signature of collector

70. Signature of comptroller

71. Signature of clerk of the court

72. Signature of sheriff

73. Signature of coroner

74. Signature of justice of the peace

75. Signature of clerk

76. Signature of recorder

77. Signature of auditor

78. Signature of treasurer

79. Signature of assessor

80. Signature of collector

81. Signature of comptroller

82. Signature of clerk of the court

83. Signature of sheriff

84. Signature of coroner

85. Signature of justice of the peace

86. Signature of clerk

87. Signature of recorder

88. Signature of auditor

89. Signature of treasurer

90. Signature of assessor

91. Signature of collector

92. Signature of comptroller

93. Signature of clerk of the court

94. Signature of sheriff

95. Signature of coroner

96. Signature of justice of the peace

97. Signature of clerk

98. Signature of recorder

99. Signature of auditor

100. Signature of treasurer

101. Signature of assessor

102. Signature of collector

103. Signature of comptroller

104. Signature of clerk of the court

105. Signature of sheriff

106. Signature of coroner

107. Signature of justice of the peace

108. Signature of clerk

109. Signature of recorder

110. Signature of auditor

111. Signature of treasurer

112. Signature of assessor

113. Signature of collector

114. Signature of comptroller

115. Signature of clerk of the court

116. Signature of sheriff

117. Signature of coroner

118. Signature of justice of the peace

119. Signature of clerk

120. Signature of recorder

121. Signature of auditor

122. Signature of treasurer

123. Signature of assessor

124. Signature of collector

125. Signature of comptroller

126. Signature of clerk of the court

127. Signature of sheriff

128. Signature of coroner

129. Signature of justice of the peace

130. Signature of clerk

131. Signature of recorder

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133. Signature of treasurer

134. Signature of assessor

135. Signature of collector

136. Signature of comptroller

137. Signature of clerk of the court

138. Signature of sheriff

139. Signature of coroner

140. Signature of justice of the peace

141. Signature of clerk

142. Signature of recorder

143. Signature of auditor

144. Signature of treasurer

145. Signature of assessor

146. Signature of collector

147. Signature of comptroller

148. Signature of clerk of the court

149. Signature of sheriff

150. Signature of coroner

151. Signature of justice of the peace

152. Signature of clerk

153. Signature of recorder

154. Signature of auditor

155. Signature of treasurer

156. Signature of assessor

157. Signature of collector

158. Signature of comptroller

159. Signature of clerk of the court

160. Signature of sheriff

161. Signature of coroner

162. Signature of justice of the peace

163. Signature of clerk

164. Signature of recorder

165. Signature of auditor

166. Signature of treasurer

167. Signature of assessor

168. Signature of collector

169. Signature of comptroller

170. Signature of clerk of the court

171. Signature of sheriff

172. Signature of coroner

173. Signature of justice of the peace

174. Signature of clerk

175. Signature of recorder

176. Signature of auditor

177. Signature of treasurer

178. Signature of assessor

179. Signature of collector

180. Signature of comptroller

181. Signature of clerk of the court

182. Signature of sheriff

183. Signature of coroner

184. Signature of justice of the peace

185. Signature of clerk

186. Signature of recorder

187. Signature of auditor

188. Signature of treasurer

189. Signature of assessor

190. Signature of collector

191. Signature of comptroller

192. Signature of clerk of the court

193. Signature of sheriff

194. Signature of coroner

195. Signature of justice of the peace

196. Signature of clerk

197. Signature of recorder

198. Signature of auditor

199. Signature of treasurer

200. Signature of assessor

201. Signature of collector

202. Signature of comptroller

203. Signature of clerk of the court

204. Signature of sheriff

205. Signature of coroner

206. Signature of justice of the peace

207. Signature of clerk

208. Signature of recorder

209. Signature of auditor

210. Signature of treasurer

211. Signature of assessor

212. Signature of collector

213. Signature of comptroller

214. Signature of clerk of the court

215. Signature of sheriff

216. Signature of coroner

217. Signature of justice of the peace

218. Signature of clerk

219. Signature of recorder

220. Signature of auditor

221. Signature of treasurer

222. Signature of assessor

223. Signature of collector

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227. Signature of coroner

228. Signature of justice of the peace

229. Signature of clerk

230. Signature of recorder

231. Signature of auditor

232. Signature of treasurer

233. Signature of assessor

234. Signature of collector

235. Signature of comptroller

236. Signature of clerk of the court

237. Signature of sheriff

238. Signature of coroner

239. Signature of justice of the peace

240. Signature of clerk

241. Signature of recorder

242. Signature of auditor

243. Signature of treasurer

244. Signature of assessor

245. Signature of collector

246. Signature of comptroller

247. Signature of clerk of the court

248. Signature of sheriff

249. Signature of coroner

250. Signature of justice of the peace

251. Signature of clerk

252. Signature of recorder

253. Signature of auditor

254. Signature of treasurer

255. Signature of assessor

256. Signature of collector

257. Signature of comptroller

258. Signature of clerk of the court

259. Signature of sheriff

260. Signature of coroner

261. Signature of justice of the peace

262. Signature of clerk

263. Signature of recorder

264. Signature of auditor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4032

CERTIFICATE OF DEATH

04013
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>419 Lambeth Rd.</u>				d. STREET ADDRESS <u>419 Lambeth Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>M.</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 59</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1874</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wallace W. Dalrymple</u>				14. MOTHER'S MAIDEN NAME <u>Susan (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Evelyn Russ - 419 Lambeth Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident (repeated)</u> 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-vascular Sclerosis</u> DUE TO (c) <u>Cardiac Arrhythmia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Arrhythmia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>59</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6014 Edmondson Ave. Balto 29 Md.</u> DATE SIGNED <u>4/21/59</u> ACTUAL SIGNATURE <u>J. Nelson McKay</u> PHYSICIAN'S NAME (Type) <u>Wm. J. Dickens & Sons. Balto 17</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickens & Sons. Balto 17</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	



100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4033

CERTIFICATE OF DEATH

04014

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto - 19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ba</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS Pt.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1914 Sparrows Pt. Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>CECILIA</u> Last <u>KIRSCHNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1898</u>
9. AGE (in years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Birmingham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sharkey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	
17. INFORMANT <u>August C. Kirschner (husb.)</u>		Address <u>(husb.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Mar. 23/59</u> <u>Sym.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5, 1951</u> to <u>April 30, 1959</u> , that I last saw the deceased alive on <u>April 28, 1959</u> and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6408 N. P+ Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Tollin</u>		DATE SIGNED <u>4/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc.</u>		ADDRESS <u>Dundalk 22</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1c, Film G241, 4/17/59 fcy
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs. 9 mos 17 das</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>764 Linnard Street</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First Middle Last <u>Klippel</u>		4. DATE OF DEATH <u>April 11 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1884</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gustav Klippel</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Grob</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Records Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right cerebellopontine angle tumor</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9, 1959</u> , to <u>April 11, 1959</u> , that I last saw the deceased alive on <u>April 11, 1959</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove St. Hospital 4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		<u>Catonsville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04016

4035

Items 8,9 Film G242 5-6-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1509 O'Dell Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADELINE Middle HALL Last KNAPP				4. DATE OF DEATH Month April Day 25 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1896	
9. AGE (In years last birthday) 63 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Thomas Browning				14. MOTHER'S MAIDEN NAME Nichotie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Wm. J. Knapp, 1509 O'Dell Avenue				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

U.S. 1010

Page 1 of 1

NAME OF DECEASED [Name]		SEX [Male/Female]	
DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]	
MANNER OF DEATH [Manner]		MEDICAL HISTORY [History]	
PRESENT ILLNESS [Illness]		POST-MORTEM EXAMINATION [Examination]	
SIGNATURE OF EXAMINER [Signature]		DATE [Date]	
PLACE [Place]		COUNTY [County]	
STATE [State]		CITY [City]	



This certificate is to be filled out by the medical examiner who has examined the body of the deceased. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04017

4036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 Southerly Rd. Towson 4, Md.				d. STREET ADDRESS 911 Southerly Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle L. Last Kohlerman, Sr.				4. DATE OF DEATH Month April Day 1 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 12 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pass Bureau				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Michael Kohlerman				14. MOTHER'S MAIDEN NAME Pauline Keil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-05-6685			
17. INFORMANT F.L. Kohlerman, Jr.				Address 322 Woodlawn Rd. 10			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cardio-vascular disease (c) advanced arterio-sclerosis advanced arthritis in all joints						INTERVAL BETWEEN ONSET AND DEATH about 4 days 7 mo 9 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4 19 58 , to April 19 59 , that I last saw the deceased alive on April 19 59 , and that death occurred at 4 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter S. Niblett				ADDRESS (Street, city or town, state) 4508 N. Charles St.			
PHYSICIAN'S NAME (Type) WALTER S. NIBLETT.				DATE SIGNED 7/1			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc.				ADDRESS 1050 York Rd. 4		24a. REC'D BY REGISTRAR DATE APR 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4037

CERTIFICATE OF DEATH

04018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7611 Daniel Avenue</i>		d. STREET ADDRESS <i>1725 Montpelier Street</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Lida Blanche Kouk</i>		4. DATE OF DEATH Month Day Year <i>April 23rd 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 9, 1889</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Fairfield Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Myers</i>		14. MOTHER'S MAIDEN NAME <i>Kugler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <i>Mr. Wilbur M. Louk, 7611 Daniel Ave. #14</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio Vascular</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Renal Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-14-55</i> , 19 <i>55</i> , to <i>4-23-</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4-14-</i> , 19 <i>59</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. W. Peake</i> M.D.		ADDRESS (Street, city or town, state) <i>4508 Harford Road #14</i> DATE SIGNED <i>4/24/59</i>	
PHYSICIAN'S NAME (Type) <i>C. W. Peake</i>		<i>Baltimore, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/27/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>APR 27 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4039

CERTIFICATE OF DEATH

Reg. Dist. No. 04020

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>3206 Mayfair Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>LA FORTEZZA</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8. 31-1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Normis Hyman</u>	
14. MOTHER'S MAIDEN NAME <u>Holly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Spring Grove St. Hosp. Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic glomerulo nephritis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/12/59</u> 19 <u>59</u> , to <u>4/22</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4/22</u> 19 <u>59</u> , and that death occurred at <u>1:50 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>STELLA WACHSLER</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED <u>4/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bonair Memorial Cong.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Lennson & Bros Inc.</u> ADDRESS <u>1126 N. North Ave.</u>		24a. REC'D BY REGISTRAR <u>are</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
3927 CERTIFICATE OF DEATH									
Reg. Dist. No. 04021									
1. PLACE OF DEATH o. COUNTY Balto. MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8538 Kavanaugh Rd.					d. STREET ADDRESS 1 8538 Kavanaugh Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gillian Middle H. Last Lam					4. DATE OF DEATH Month 4 Day 21 Year 1959				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/6/20		9. AGE (In years last birthday) yrs. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter			10b. KIND OF BUSINESS OR INDUSTRY US Govrt.		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grover Lam					14. MOTHER'S MAIDEN NAME Bessie Michael				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Family			Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									INTERVAL BETWEEN ONSET AND DEATH 1/2 hour
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 Nov. 19 58 , to 21 April 19 59 , that I last saw the deceased alive on 21 April 19 59 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Morris Rainess M.D.					ADDRESS (Street, city or town, state) 2900 DUNRAN RD			DATE SIGNED 4-22-59	
PHYSICIAN'S NAME (Type) MORRIS RAINESS, M.D. DUNDALK 22, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY National Cem.			22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.					24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,

7394

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First JOHN		Middle MAIN		Last LAWRENCE		4. DATE OF DEATH Month April		Day 30,		Year 1959		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx.		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58		IF UNDER 24 HRS. Days 58		Hours 58		Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)				17. INFORMANT				Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																													
ACTUAL SIGNATURE R. F. Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/30/59													
EXAMINER'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify)														22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR DATE AUG 13 '59				24b. REGISTRAR'S SIGNATURE Richard S. Howard																	

MEDICAL CERTIFICATION

of removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4040

CERTIFICATE OF DEATH

04022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN IB 9 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		d. STREET ADDRESS 110 Chambers Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Ann Layton		4. DATE OF DEATH Month Day Year April 15, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/43
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Hutchinson Layton		14. MOTHER'S MAIDEN NAME Lilly Anne Spicer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to Mitral stenosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 50 , to April 15 , 19 59 , that I last saw the deceased alive on April 15 , 19 59 , and that death occurred at 5:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		4307 Mainfield Ave, Baltimore	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/15/59	
22c. NAME OF CEMETERY OR CREMATORY Odds Fellows		22d. LOCATION (City, town, or county) (State) SEALED DE	
23. FUNERAL DIRECTOR'S SIGNATURE Howard S. Kuppala		ADDRESS 4107 Williams ave.	
24a. REC'D BY REGISTRAR APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

4.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. 4041 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn L. Martin Co.-Martin Plant Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fork d. STREET ADDRESS Upland Rd. and Wilson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle ARTHUR Last LEHNER		4. DATE OF DEATH Month April Day 17 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Detail Mfg. Dept.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME August J. Lehner		14. MOTHER'S MAIDEN NAME Pauline A. Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anita B. Lehner - Fork, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Natural Cause DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Jack C Collins, Deputy Medical Examiner PHYSICIAN'S NAME (Type) Jack C Collins Balt 22			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/59	
22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tietner		24a. REC'D BY REGISTRAR DATE APR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

CERTIFICATE OF DEATH

Reg. No. 112

THIS CERTIFICATE MUST BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED OR BY THE PHYSICIAN WHO FIRST EXAMINES THE BODY OF THE DECEASED.

1. Name of Deceased: _____

2. Date of Death: _____

3. Place of Death: _____

4. Age of Deceased: _____

5. Sex of Deceased: _____

6. Race of Deceased: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Physician: _____

10. Date of Signature: _____

11. Signature of Registrar: _____

12. Date of Registration: _____

13. Signature of Coroner: _____

14. Date of Coroner's Report: _____

15. Signature of Medical Examiner: _____

16. Date of Medical Examiner's Report: _____

17. Signature of Health Officer: _____

18. Date of Health Officer's Report: _____

19. Signature of Registrar: _____

20. Date of Registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04024

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 605 1/2 Aldershot Road		d. STREET ADDRESS 1 605 1/2 Aldershot Road	
3. NAME OF DECEASED (Type or print) First HELEN Middle F. Last LIPSITZ		4. DATE OF DEATH Month April Day 14 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --	9. AGE (In years last birthday) 47 yrs.
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Wm. H. Ridenour		14. MOTHER'S MAIDEN NAME Edna Mae Funk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. Richard E. Ridenour-839 Widewood Pkwy.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Over dosage of barbiturate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 970.2 (c) PARTIAL		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took over dose of barbiturate	
20c. TIME OF INJURY Month, Day, Year Hour a. m. unknown 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House
20f. (City or town) 605 1/2 Aldershot Road, Catonsville		(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 4/15/59
EXAMINER'S NAME (Type) William V. Lovitt, Jr.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Pickner & Sons - Balt</i>	ADDRESS 17	24a. REC'D BY REGISTRAR APR 20 '59	24b. REGISTRAR'S SIGNATURE <i>Wm. J. Pickner</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4043

CERTIFICATE OF DEATH

04025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Catonsville</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
c. LENGTH OF STAY IN 1b <u>16 yrs. 5 mo 27 d.</u>				d. STREET ADDRESS <u>1801 N. Fulton St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Adele Rosemthower Lowenstein</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Aaron Rosemthower</u>			
14. MOTHER'S MAIDEN NAME <u>Dora Dutch</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____			
16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>Records from Spring Grove State Hospital</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio-vascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct. 24</u> , 19 <u>42</u> , to <u>April 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>59</u> , and that death occurred at <u>5 p.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. D. Drinkard</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>James Donald Drinkard, M.D.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meshkin Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lowenthal</u> ADDRESS <u>2100 Cutaw Place</u>				24a. REC'D BY REGISTRAR <u>APR 21 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. RACE</p> <p>5. BIRTH DATE</p> <p>6. BIRTH PLACE</p> <p>7. MARRIAGE DATE</p> <p>8. MARRIAGE PLACE</p> <p>9. OCCUPATION</p> <p>10. CAUSE OF DEATH</p> <p>11. PLACE OF DEATH</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. SIGNATURE OF DECEASED</p> <p>15. SIGNATURE OF WITNESS</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF CLERK</p> <p>18. SIGNATURE OF JUDGE</p> <p>19. SIGNATURE OF SHERIFF</p> <p>20. SIGNATURE OF TOWNSHIP CLERK</p> <p>21. SIGNATURE OF COUNTY CLERK</p> <p>22. SIGNATURE OF STATE CLERK</p> <p>23. SIGNATURE OF DEPARTMENT CLERK</p> <p>24. SIGNATURE OF HEALTH COMMISSIONER</p> <p>25. SIGNATURE OF GOVERNOR</p>	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

4045 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04027
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAPE MAY BEACH		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAPE MAY BEACH	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1939 CAPE MAY BEACH ROAD			d. STREET ADDRESS 1939 CAPE MAY BEACH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FERDINARD MARDAGA			4. DATE OF DEATH Month Day Year APRIL 30, 1959 19		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8, 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.	
13. FATHER'S NAME LOUIS MARDAGA			14. MOTHER'S MAIDEN NAME MARY GROB		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. LOUIS MARDAGA Address PITTSBURG PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V DISEASE 422.1 DUE TO SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) None		20g. (County) None		20h. (State) None	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M. B. Davis			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) M. B. DAVIS MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 5/1/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 4, 1959		22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK	
22d. LOCATION (City, town, or county) WOODLAWN MARYLAND.					
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.			24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House

may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4046

CERTIFICATE OF DEATH

Reg. Dist. No.

04028

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3623 Forest Hill Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle O. Last McCAULEY				4. DATE OF DEATH Month April Day 15 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1884	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Alexander E. Orr		14. MOTHER'S MAIDEN NAME Frances A. Young		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert Kelly		18. ADDRESS 0 3623 Forest Hill Rd.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH four hours 10 years 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *****				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ***** 19 59 p. m. *****				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> *****			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****				20f. (City or town) (County) (State) *****			
21. I certify that I attended the deceased from 19 57 to April 19 59 , that I last saw the deceased alive on 21 February 19 59 , and that death occurred at 6:45A :M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Ave. Balt. 74 Md. DATE SIGNED 4/17/59							
ACTUAL SIGNATURE Millard T. Traband				M.D. 5101 Gwynn Oak Ave. Balt. 74 Md. 4/17/59			
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D.				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner				24a. REC'D BY REGISTRAR DATE APR 20 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]							

345

1. The first group of respondents (n = 10) was composed of students who had completed the course and were currently employed in the field of international business. The second group (n = 10) was composed of students who had completed the course and were currently employed in the field of international business. The third group (n = 10) was composed of students who had completed the course and were currently employed in the field of international business.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4047

CERTIFICATE OF DEATH

04029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rodgers Forge.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 222 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle J. Last McCourt.		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired buyer		10b. KIND OF BUSINESS OR INDUSTRY Stewart & Co	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael J. McCourt.		14. MOTHER'S MAIDEN NAME Mary Appleton.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mary Noppenberger. 220 Murdock Road.	
17. INFORMANT Mary Noppenberger. 220 Murdock Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Hypertension C - V Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Atherosclerosis Generalized (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 d		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6, 19 59 to April 8, 19 59 , that I last saw the deceased olive on April 6, 19 59 and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		21. I certify that I attended the deceased from April 6, 19 59 to April 8, 19 59 , that I last saw the deceased olive on April 6, 19 59 and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Charles E. Carr, Jr., M.D.		M.D. 6201 York Road, Baltimore 12, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Old Frederick Rd, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan 3818 Roland Ave		24a. REC'D BY REGISTRAR APR 10 1959	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CELEBRATE OF DEATH

592

1 **TO HOSPITAL OR FUNERAL HOME:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4048

CERTIFICATE OF DEATH

Reg. Dist. No.

04030

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robbs Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth M. Meigs</u>		4. DATE OF DEATH Month Day Year <u>April 22, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1876</u>
9. AGE (In years lost birthday) yrs. <u>82</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8 21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Delvine Marean</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brewster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-20-1921</u>	
17. INFORMANT <u>Drs. Helen Rea, Pikesville 8, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>75 yrs</u> <u>75 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-6-</u> , 19 <u>59</u> , to <u>4-22-</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>4-22-</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Ramapuram</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 Marston Rd, Balt, Md. 4/23/59</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE RAMAPURAM Md.</u>		<u>7501 MARSTON Rd. Balt, Md. 4/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 25, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4049
CERTIFICATE OF DEATH04031
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3412 Old Forest Road</u>		d. STREET ADDRESS <u>13412 Old Forest Rd</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>MELNICK</u> Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>69</u> yrs.
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Arthur Klein - Pikesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION</u> DUE TO (b) <u>420.1</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 16, 1959</u> to <u>APRIL 16, 1959</u> that I last saw the deceased alive on <u>April 16, 1959</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon E. Kassel</u>		ADDRESS (Street, city or town, state) <u>3501 St. Paul Street, Balto., Md.</u>	
PHYSICIAN'S NAME (Type) <u>LEON E. KASSEL, M.D.</u>		M.D. <u>3501 St. Paul St., Balto. 18, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beth David</u>		22d. LOCATION (City, town, or county) (State) <u>Elmont L.I. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>APR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Klein</u>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

VS A15 (4)
15M 9/58

1000

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SEVEN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04033
Reg. Dist. No.

4051

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1902 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Miller Sr. Last Miller Sr.		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hardwood Floor Man	9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Estonia		12. CITIZEN OF WHAT COUNTRY? Estonia ✓	
13. FATHER'S NAME Johan Willman		14. MOTHER'S MAIDEN NAME Liisu Wakker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-14-9600	17. INFORMANT Mrs. Lillian Miller Address 1902 Summit Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/21/1956 , to 4/21/1959 , that I last saw the deceased alive on 4/21/1959 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3800 Badman Ave #13 DATE SIGNED Md.			
ACTUAL SIGNATURE Paul H. Anniko M.D.		22a. REC'D BY REGISTRAR APR 6 '59	
PHYSICIAN'S NAME (Type) PAUL H. ANNIKO		24b. REGISTRAR'S SIGNATURE Arthur S. Haus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 6/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 1901 Eastern Ave.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4052
CERTIFICATE OF DEATH

04034

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 18 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 BALTIMORE (27)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3306 BERO ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTIN		First Middle Last -- MILLER		4. DATE OF DEATH APRIL		Day Year 12 19 59	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 23, 1873	
9. AGE (In years last birthday) yrs. 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10b. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME ISAAC MILLER				14. MOTHER'S MAIDEN NAME CATHERINE FARLOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. OW		17. INFORMANT Address CLIN REC VET ADM HOSP FORT HOWARD MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT, OLD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEVERE CORONARY ARTERIOSCLEROSIS WITH NARROWING AND OLD OCCLUSION LEFT ARTERIAL DESCENDING BRANCH (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25 , 19 59 , to April 12 , 19 59 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Ft. Howard, Md 4/13/59							
ACTUAL SIGNATURE W. W. Schier M.D.		M.D. VAH Ft. Howard, Md					
PHYSICIAN'S NAME (Type) W. W. SCHIER, M.D.		VAH Ft. Howard, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hubbard Funeral Home 4107 Wilkens Ave. Balto. Md				24a. REC'D BY REGISTRAR DATE APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT.

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VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glyndon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longnecker Road		d. STREET ADDRESS Longnecker Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harold First Pierce Middle Montanye Last		4. DATE OF DEATH April 6, 1959 Month April Day 6 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Writer		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stanley S. Montanye		14. MOTHER'S MAIDEN NAME Lillian A. Montanye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) W.M.I.		16. SOCIAL SECURITY NO. 040-28-4851	
17. INFORMANT Mr. C. N. Montanye, Glyndon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic C-V Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8/59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 18 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Sea Bright Avenue				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk 22 d. STREET ADDRESS 6 Sea Bright Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First CHARLES Middle ELMER Last MOORE				4. DATE OF DEATH Month April Day 1st Year 19 59													
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5th, 1879		9. AGE (In years last birthday) 79 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st Helper				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Jefferson Moore				14. MOTHER'S MAIDEN NAME Anne Price													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-09-0582		17. INFORMANT Mrs. D.S. Nesbitt Address same as #2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 min 24 hr.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Jack E Collins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4-1-59									
EXAMINER'S NAME (Type) Jack E Collins				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 4/4/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thomas</i>				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4054

CERTIFICATE OF DEATH

04037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX 54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904 WOODWARD DRIVE</u>		d. STREET ADDRESS <u>904 WOODWARD DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>M</u> Middle <u>MOORE</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 17, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE HOLZSHOE</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. WM. MOORE</u>		Address <u>904 WOODWARD DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 158X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, retroperitoneal with lymph node & liver metastasis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>59</u> , and that death occurred at <u>1:05 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles M. Kerr</u> M.D.		ADDRESS (Street, city or town, state) <u>6801 Belair Rd</u> DATE SIGNED <u>4/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles M. Kerr</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 Eastern Blvd. 21</u>	
24a. REC'D BY REGISTRAR <u>APR 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles M. Kerr</u>	

CERTIFICATE OF DEATH

024

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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IN AMERICAN CITY
1917

4055

CERTIFICATE OF DEATH

04038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>			c. LENGTH OF STAY IN 1b X <u>Baldwin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cherry Hill Road</u>				d. STREET ADDRESS <u>Cherry Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Mary</u> Last <u>Mueller</u>				4. DATE OF DEATH Month <u>4-</u> Day <u>8-</u> Year <u>19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894</u> <u>Dec. 10, 1897</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Neward, New Jersey</u>	
13. FATHER'S NAME <u>George Mc Caffrey</u>				14. MOTHER'S MAIDEN NAME <u>Emma Sterncoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Michael J. Mueller, same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Severe</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>56</u> to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>4-9-59</u>			
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Long Green, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.J. Ruck, Inc. 5305 Harford Rd. #14</u>				24a. REC'D BY REGISTRAR DATE <u>APR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04039

Reg. Dist. No.

4056

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1751 Wycliff Rd</u>			e. STREET ADDRESS <u>1751 Wycliff Rd</u>		
3. NAME OF DECEASED (Type or print) <u>EVERLYN</u> First <u>ELARA</u> Middle <u>MULLEN</u> Last			4. DATE OF DEATH <u>April</u> Month <u>11</u> Day <u>19</u> Year <u>59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/21</u>		9. AGE (in years last birthday) <u>37</u> yrs. Months <u>3</u> Days <u>3</u> Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>State Rd Comm</u>		11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Fred B. Chewing</u>		
14. MOTHER'S MAIDEN NAME <u>Bessie Hughes</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>227-16-8046</u>			17. INFORMANT <u>Mrs. Grace Burke</u> Address <u>4936 Schaub Avenue</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hanging</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>apparent suicidal hanging</u>		
20c. TIME OF INJURY Month <u>4</u> Day <u>11</u> Year <u>1959</u> Hour <u>600</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			20f. City or town <u>Balto</u> (County) <u>Balto</u> (State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR MD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>4/11/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		22e. REC'D BY REGISTRAR <u>APR 14 '59</u>		22f. REGISTRAR'S SIGNATURE <u>Charles S. Hunt</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>					

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935

NAME OF DECEASED JOHN J. BROWN
RESIDENCE 1234 E. BALTIMORE ST.
CITY BALTIMORE STATE MARYLAND

DATE OF DEATH 10-15-35 TIME OF DEATH 10:30 AM
PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE
MANNER OF DEATH NATURAL

DECEASED'S AGE 65 SEX MALE
OCCUPATION CLERK

DECEASED'S BIRTH DATE 1870 BIRTH PLACE MD
MARRIED YES SPOUSE'S NAME MARY J. BROWN

DECEASED'S PRESENT ADDRESS 1234 E. BALTIMORE ST.
DECEASED'S PREVIOUS ADDRESS NONE

DECEASED'S PRESENT OCCUPATION CLERK
DECEASED'S PREVIOUS OCCUPATION NONE

DECEASED'S PRESENT RESIDENCE 1234 E. BALTIMORE ST.
DECEASED'S PREVIOUS RESIDENCE NONE

DECEASED'S PRESENT CITY BALTIMORE STATE MARYLAND
DECEASED'S PREVIOUS CITY NONE STATE NONE

DECEASED'S PRESENT COUNTRY USA
DECEASED'S PREVIOUS COUNTRY NONE

DECEASED'S PRESENT RACE WHITE
DECEASED'S PREVIOUS RACE NONE

DECEASED'S PRESENT RELIGION CATHOLIC
DECEASED'S PREVIOUS RELIGION NONE

DECEASED'S PRESENT ETHNIC ORIGIN IRISH
DECEASED'S PREVIOUS ETHNIC ORIGIN NONE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4057

CERTIFICATE OF DEATH

04040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4214 Cardwell Ave.</u>		d. STREET ADDRESS <u>4214 Cardwell Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry L. Mullen</u>		4. DATE OF DEATH <u>April 29, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Mary Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-0303</u>	
17. INFORMANT <u>Lawrence L. Mullen</u>		Address <u>4214 Cardwell Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Myocardial degeneration Diffuse.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Inst.??</u> <u>undet.</u> <u>undet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Endoelbow, malnutrition & Anorexia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Apr 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr - 27</u> , 19 <u>59</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hyle</u>		ADDRESS (Street, city or town, state) <u>7527 Belair Rd</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		DATE SIGNED <u>4-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Essex Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

1-1-1918

<p>1. Name of deceased: <u>JOHN J. HARRIS</u></p>	
<p>2. Age: <u>45</u> years</p>	
<p>3. Sex: <u>Male</u></p>	
<p>4. Race: <u>White</u></p>	
<p>5. Date of death: <u>Dec 15 1917</u></p>	
<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Signature of physician: <u>[Signature]</u></p>	
<p>9. Signature of registrar: <u>[Signature]</u></p>	
<p>10. Date of filing: <u>Dec 18 1917</u></p>	

This certificate is first issued by the State Department of Health, Baltimore, Maryland, and is subject to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1917, Chapter 100, and to the regulations of the State Department of Health, Baltimore, Maryland, and is subject to the provisions of the Act of the General Assembly of the State of Maryland, passed at the Session of 1917, Chapter 100, and to the regulations of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 FilmG241 4-20-59 et

4058

CERTIFICATE OF DEATH

04041
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>		c. LENGTH OF STAY IN 1b <u>RODGERS FORGE Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>233 Rodgers Forge Rd</u>		d. STREET ADDRESS <u>233 RODGERS FORGE Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Todd</u> Middle <u>Mulvenny</u> Last		4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 17 1897</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice-Consul</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>British</u>	
11. BIRTHPLACE (State or foreign country) <u>Douglas Isle of MAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND</u>	
13. FATHER'S NAME <u>ROBERT MULVENNY</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE MONAGHAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Joseph Todd Mulvenny Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>? yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2/45</u> , 19 <u>—</u> , to <u>4/14/59</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>4/14/59</u> , 19 <u>—</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis M. Glueck</u>		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Apr. 16 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins & Sons Co</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial	
17. Signature of interment		18. Signature of cremation		19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04042

4059

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 53 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 901 N. Appleton Street	
3. NAME OF DECEASED (Type or print) First CHARLES Middle L Last NASH		4. DATE OF DEATH Month April Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Dairy Co	
11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles L Nash		14. MOTHER'S MAIDEN NAME Anna Burgess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-10-3941	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH METASTASES TO REGIONAL LYMPH NODES, PANCREAS, LIVER AND COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 1959 , to April 7, 1959 and that death occurred at 9:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FT HOWARD, MARYLAND 4/8/59 ACTUAL SIGNATURE John W. Crawford M.D. PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home 1631 Druid Hill Ave Balto Md		24a. REC'D BY REGISTRAR APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 00000
 CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John A. Smith		April 15, 1942	
Age		35	
Sex		Male	
Race		White	
Marital Status		Married	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Atherosclerosis	
Contributing Cause		Hypertension	
Manner of Death		Natural	
Signature of Physician		J. H. Jones, M.D.	
Signature of Registrar		A. B. Smith	
Date of Registration		April 16, 1942	
Place of Registration		Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3929

CERTIFICATE OF DEATH

04043
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6739 Holabird Ave.				d. STREET ADDRESS 6739 Holabird Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle BELLE Last NEALIS				4. DATE OF DEATH Month April Day 18 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.		IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas J. Parker				14. MOTHER'S MAIDEN NAME Margaret Strasbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. Wm. Nealis 6739 Holabird Ave.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIO SCLEROTIC C.V.D.S. (c) INFECTED ULCER LEFT LEG				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INFECTED ULCER LEFT LEG				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 16, 1959 to Apr 18, 1959 that I last saw the deceased alive on Apr 18, 1959 , and that death occurred at 7 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 6714 Holabird Ave DATE SIGNED Stephen C. Mackowiak			
ACTUAL SIGNATURE Stephen C. Mackowiak M.D.							
PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK				BALTIMORE 22 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF April 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

INFECTED ULCER LEFT LEG

ARTERIO SCLEROSIS D.V.D.2
CORONARY ARTERY DISEASE

STEPHEN V. HAKOWIAK
6410 N. 1st Ave.
CHICAGO, ILL. 60631
OFFICE 214-2111

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in case of an inquest event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4060

CERTIFICATE OF DEATH

04044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK M. NICODEMUS		4. DATE OF DEATH Month April Day 8 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71	11. IF UNDER 24 HRS. Days 71 Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME John J. Nicodemus		14. MOTHER'S MAIDEN NAME Elizabeth Copes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Elizabeth A. Bull - 8201 LaSalle Rd.		Address 8201 LaSalle Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 17, 1959 , to April 8, 1959 , that I last saw the deceased alive on April 8, 1959 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 Mallow Hill Ave., Baltimore 29, Maryland. DATE SIGNED 4/8/59			
ACTUAL SIGNATURE Leo J. Gaver, M.D.		M.D. 1 Mallow Hill Ave., Baltimore 29, Maryland.	
PHYSICIAN'S NAME (Type)		DATE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/59	
22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17		24a. REC'D BY REGISTRAR APR 14 1959	
ADDRESS Baltimore 17		24b. REGISTRAR'S SIGNATURE Wm. J. Lickner	

1

25. 10. 1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04045

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDonogh		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McDonogh School, McDonogh Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4	
3. NAME OF DECEASED (Type or print) FLORENCE MAY O'CONNELL		4. DATE OF DEATH Month Apr. Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irven Neckerman		14. MOTHER'S MAIDEN NAME Sarah Jane Isett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Madeline O'Connell		Address 1309 W. Belvedere Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of hip, right DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home 20c. TIME OF INJURY Month, Day, Year Hour o. m. Mar. 31 59 p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Baltimore City, Md.			INTERVAL BETWEEN ONSET AND DEATH 24 days several yrs
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemon		24a. REC'D BY REGISTRAR DATE APR 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G242 5-18-59 et
4062
CERTIFICATE OF DEATH

04046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr5mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2513 Ashland Avenue	
3. NAME OF DECEASED (Type or print) Casemina First Minnie Middle Anarenas Last Palma		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown Approx. 46 yrs.
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Sicily, Italy	
11. BIRTHPLACE (State or foreign country) Sicily, Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony Roleosa		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 115-20-5321	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9 , 19 59 , to 4-8-59 , 19 59 , that I last saw the deceased alive on 4-8- , 19 59 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-9-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS 3331 Brehms Lane	
24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TAI M BOND

THE TAI M BOND CO. OF
HONG KONG
INCORPORATED IN HONG KONG
CAPITAL \$1,000,000
RESERVE FUND \$1,000,000
TOTAL ASSETS \$2,000,000
TAI M BOND CO. OF HONG KONG
INCORPORATED IN HONG KONG
CAPITAL \$1,000,000
RESERVE FUND \$1,000,000
TOTAL ASSETS \$2,000,000

STATE OF NEW YORK
CERTIFICATE OF DEATH

1900

County of _____

City of _____

State of New York

On the _____ day of _____ 1900

at _____

I, _____

do hereby certify that _____

was born on the _____ day of _____ 1900

at _____

and died on the _____ day of _____ 1900

at _____

of _____

caused by _____

and was buried on the _____ day of _____ 1900

at _____

by _____

Witness my hand and seal this _____ day of _____ 1900

at _____

Notary Public for the State of New York

Schimunek Funeral Home

CHARLES E. SCHIMUNEK, FUNERAL DIRECTOR

3331 BREHMS LANE
BALTIMORE 13, MARYLAND

TELEPHONE - DICKENS 2-4900

You will please note, there is not available at this time, date of birth or correct age. A lawyer in New York is working on this and as soon as he can secure same for us, we will forward the information on to you to insert on the death certificate, at which time, we will order transcripts.

Thanks a lot.

*Correction of Miss S Rodgers
age to come in*

CHURCH OF THE
SACRAMENT

CHURCH OF THE
SACRAMENT

CHURCH OF THE
SACRAMENT



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkton, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Virginia</u> Last <u>Pearson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/09</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Pearson (deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hoshall (deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pneumonia</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>525X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral insufficiency</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/19/59</u> , 19 <u>59</u> , to <u>4/19/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/19/59</u> , 19 <u>59</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		DATE SIGNED <u>4/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Marlfield Ave City #14</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>April 27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline</u>		ADDRESS <u>Sms Ruststown</u>	
24a. REC'D BY REGISTRAR <u>APR 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 908 DANTREY COURT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle J Last PETERSON		4. DATE OF DEATH Month 4 Day 30 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS LEONARD		14. MOTHER'S MAIDEN NAME ELOISE BURRUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9- , 19 59 , to 4-30- , 19 59 , that I last saw the deceased alive on 4-30- , 19 59 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-59	
22c. NAME OF CEMETERY OR CREMATORY Bethel National Am.		22d. LOCATION (City, town, or county) (State) Bethel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCallie Weaver/Homes		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

CERTIFICATE OF DEATH

Date of Death _____		Place of Death _____	
Name of Deceased _____		Sex _____	
Age _____		Race _____	
Date of Birth _____		Place of Birth _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

RECEIVED
BUREAU OF VITAL RECORDS
JAN 10 1910

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
JAN 10 1910

CERTIFICATE OF DEATH

04049

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 YEAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>POLCAK</u> Last <u>POLCAK</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUTCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEAT PACKERS</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAK</u>		12. CITIZEN OF WHAT COUNTRY? <u>CZECHOSLOVAK</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-0565A</u>	
17. INFORMANT <u>MRS. ROSE KALIVODA</u> Address <u>303 SEWARD AVE.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 422.1 DUE TO <u>Cardiovascular disease</u> ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> } (c) <u>Generalized arteriosclerosis</u> }	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>59</u> to <u>April 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>59</u> , and that death occurred at <u>10:12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>GEO. SM. KIEFFER</u> M.D.		ADDRESS (Street, city or town, state) <u>1010 LEACH ST BALTO MD</u>	
DATE SIGNED <u>April 13 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LODGEON PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schaub</u> ADDRESS <u>3512 Frederick Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or reburial, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04050

Reg. Dist. No.

4066

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRACELAND PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 526 S. 45TH ST.			d. STREET ADDRESS 526 S. 45TH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELI Middle POPE Last JR.			4. DATE OF DEATH Month APRIL Day 25 Year 1959.		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20, 1916.	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LEADER		10b. KIND OF BUSINESS OR INDUSTRY MD. DRYDOCK CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME ELI POPE, SR.			14. MOTHER'S MAIDEN NAME FLORENCE O'SAN.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address NELLIE LOU POPE SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO INJURY			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. DAVIS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/25/59	
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-28-59		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	
				22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jaler		ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR DATE APR 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

NAME OF DECEASED JAMES H. WHITE		AGE 45		SEX Male	
DATE OF DEATH April 15, 1945		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		LOCALITY OF DEATH Baltimore, Md.	
DISEASE OR INJURY Coronary Artery Disease		PREVIOUS ILLNESS Hypertension		TREATMENT None	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		HISTORY Long standing		FAMILY HISTORY None	
POST-MORTEM EXAMINATION None		LABORATORY EXAMINATIONS None		RADIOLOGICAL EXAMINATIONS None	
SIGNATURE OF EXAMINER J. H. White		DATE April 15, 1945		PLACE Baltimore, Md.	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04051
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Upper Ruhl Rd.</u>		e. STREET ADDRESS <u>Upper Ruhl Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Thomas Pruitt</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr 20, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seaman.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-164483</u>	
17. INFORMANT <u>C. F. Thrift, Jr., Freeland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hertenstein, New Freedom, Pa.</u>		24. REGISTRAR'S SIGNATURE <u>Orlino S. France</u>	
30. REC'D BY REGISTRAR <u>APR 28 '59</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYNARD STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0-1051

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several horizontal sections with various labels and checkboxes.

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

DETAILS OF DEATH: _____

EXAMINER'S SIGNATURE: _____

DATE: _____

LOCATION: _____

ADDITIONAL INFORMATION: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3930

CERTIFICATE OF DEATH

04052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 DETROIT AVE</u>				d. STREET ADDRESS <u>202 DETROIT AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM OTIS RHUDY</u>				4. DATE OF DEATH Month Day Year <u>APRIL 29 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 28, 1910</u>	9. AGE (In years lost birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM B. RHUDY</u>				14. MOTHER'S MAIDEN NAME <u>SUSIE CORNETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>243-036431</u>		INFORMANT Address <u>MRS. HELEN RHUDY 202 DETROIT AV.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X Carcinoma Lungs</u> DUE TO (b) <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1959</u> to <u>April 29, 1959</u> , that I last saw the deceased alive on <u>April 28, 1959</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David H. Andrew</u> M.D.				ADDRESS (Street, city or town, state) <u>33 Dundalk Ave</u> DATE SIGNED <u>4/29/59</u>			
PHYSICIAN'S NAME (Type) <u>David H. Andrew</u>				<u>Dundalk 2217d</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUMMERFIELD CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>INDEPENDENCE VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>				24a. REGISTRY BY REGISTER <u>MAY 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hurd</u>	

07023

FOR INFORMATION ONLY

3320

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4068 CERTIFICATE OF DEATH

04053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home				d. STREET ADDRESS 611 Morris Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude H. Rock				4. DATE OF DEATH Month Day Year April 6, 1959 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13 1873		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Carruthers				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give year or date of service) *****		17. INFORMANT Ferinand W. Rock		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Amputation mid thigh left							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18. recent)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to 6 April 59 , that I last saw the deceased alive on 5 April 59 , and that death occurred at 4:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville Md DATE SIGNED 7 April 1959							
ACTUAL SIGNATURE W. E. McGrath M.D.		PHYSICIAN'S NAME (Type) W. E. McGrath M.D. Catonsville Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9/59		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. D. Wipperf				ADDRESS 1300 Eutaw Pl.		24a. REC'D BY REGISTRAR DATE APR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4069

CERTIFICATE OF DEATH

04054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 83 Brookfield Road	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HARVEY Middle E. Last ROTZELL		4. DATE OF DEATH Month April Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min. 59	11. BIRTHPLACE (State or foreign country) U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Chicken Farm	
11. BIRTHPLACE (State or foreign country) Kneedler, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Salvester C. Rotzell	14. MOTHER'S MAIDEN NAME Emma Gable
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW I	16. SOCIAL SECURITY NO. 219-01-3252	17. INFORMANT Clin Records, Vet. Administration Hosp Ft. Howard, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 7, 1959 , to April 12, 1959 , and that death occurred at 1:10 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Samuel J. Mangus	DATE SIGNED 4/12/59
PHYSICIAN'S NAME (Type) SAMUEL J. MANGUS, M.D.	ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland
	DATE SIGNED 4/12/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Funeral Home, Wolfe & Eastern Ave	ADDRESS Balto. Md.	24a. REC'D BY REGISTRAR APR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraw...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04055

Reg. Dist. No.

4070

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6yr3mth13dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 5006 Kensaw Street	
3. NAME OF DECEASED (Type or print) First George Middle F. Last ROUSSILLON Rousillon		4. DATE OF DEATH Month April Day 20 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Rousillon		14. MOTHER'S MAIDEN NAME Mary Salumbo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 570-07-4028	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensatory heart disease 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cor Pulmonale DUE TO (c) Pulmonary emphysema		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 7, 1953 , to April 20, 1959 , that I last saw the deceased alive on April 20, 1959 , and that death occurred at 6:00a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-20-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/59	
22c. NAME OF CEMETERY OF CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co Inc		ADDRESS 517 11th St SE	
24a. REC'D BY REGISTRAR APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 CERTIFICATE OF DEATH

1907

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES BOND		Male		35		White		Carpenter	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
Baltimore, Md.		Jan 15, 1872		Baltimore, Md.		Jan 15, 1907		10:30 AM	
11. CAUSE OF DEATH		12. MEDICAL HISTORY		13. HISTORY OF PRESENT ILLNESS		14. POST-MORTEM EXAMINATION		15. SIGNATURE OF PHYSICIAN	
Heart failure		None		Sudden		None		J. B. Bond	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF BURIAL OFFICER	
J. B. Bond		J. B. Bond		J. B. Bond		J. B. Bond		J. B. Bond	

RECEIVED
 JAN 16 1907
 BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4071

CERTIFICATE OF DEATH

04056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10yr9mth18days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2215 Boyer Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eliza		First Eliza		Middle Ruberry		Last	
4. DATE OF DEATH April 8 19 59		Month April		Day 8		Year 19 59	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1864	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bartholomew Ruberry				14. MOTHER'S MAIDEN NAME Ann McDonough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3 19 59 , to 4-8-19 59 , that I last saw the deceased alive on 4-8-59 19 59 , and that death occurred at 10 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 4-9-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Apr 9 1959 New Cathedral Cem		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Old Frederick Rd Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Duff Bros 1800 E Lombard St		ADDRESS		24a. REC'D BY REGISTRAR APR 14 59		24b. REGISTRAR'S SIGNATURE Carlton S. H...	

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04057

4072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E Last SCHERTLE		4. DATE OF DEATH Month APRIL Day 7 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 10, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	9. AGE (In years last birthday) yrs. 50
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY SCHERTLE		14. MOTHER'S MAIDEN NAME MARY WAGNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 4, 1959 , to April 7, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD DATE SIGNED 4/8/59 ACTUAL SIGNATURE John W. Crawford M.D. PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Apr. 10, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley 700 Willow Spring Rd Balto. Md		24a. REC'D BY REGISTRAR APR 9 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hanes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES J. JONES</p>		<p>DATE OF DEATH JANUARY 10, 1900</p>	
<p>AGE 30</p>		<p>SEX MALE</p>	
<p>PLACE OF BIRTH BALTIMORE, MARYLAND</p>		<p>RESIDENCE BALTIMORE, MARYLAND</p>	
<p>OCCUPATION CLOCKMAKER</p>		<p>CAUSE OF DEATH DIPHTHERIA</p>	
<p>DATE OF BURIAL JANUARY 12, 1900</p>		<p>PLACE OF BURIAL CATHOLIC CEMETERY</p>	
<p>SIGNATURE OF PHYSICIAN J. J. JONES</p>		<p>SIGNATURE OF REGISTRAR J. J. JONES</p>	
<p>DATE OF REGISTRATION JANUARY 10, 1900</p>		<p>PLACE OF REGISTRATION BALTIMORE, MARYLAND</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4073

CERTIFICATE OF DEATH

04058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 81 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL J SCHMITT		4. DATE OF DEATH Month Day Year April 14 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Men's Furnishings	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Phil Schmitt		14. MOTHER'S MAIDEN NAME Marie Schmitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 212-09-9124	
17. INFORMANT Clin. Records, Veterans Adm. Hospital Ft Howard Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 23, 19 59 to April 14, 19 59 , and that death occurred at 9:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FT HOWARD, MD 4/14/59			
ACTUAL SIGNATURE W. W. Schier		M.D. VAH FT HOWARD, MD	
PHYSICIAN'S NAME (Type) W. W. SCHIER, M.D.		VAH Ft. Howard, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H Hubbard		ADDRESS 1107 Wilkens Ave. Balto. Md	
24a. REC'D BY REGISTRAR APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

3931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>DUNDALK 53</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1950 WAREHAM RD</u>		d. STREET ADDRESS <u>1950 WAREHAM RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ADAM</u> Middle <u>SCHREIBER</u> Last <u>SCHREIBER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOX</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM SCHREIBER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE SEIBERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-7675</u>	
INFORMANT <u>ELROY SCHREIBER</u>		Address <u>1950 WAREHAM</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>mitral Stenosis</u> DUE TO (c) <u>Rheumatic Fever</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>20 years</u> <u>21 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1954</u> to <u>Apr 28, 1959</u> , that I last saw the deceased alive on <u>Apr 28, 1959</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		ADDRESS (Street, city or town, state) <u>1010 North Point Rd</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>		DATE SIGNED <u>4/29/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLBACH LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME DUNDALK MD</u>		ADDRESS <u>WILLIAM FUNERAL HOME DUNDALK MD</u>	
24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3231

DEATH

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04060

4074

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>7 TOWSON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> 3Y01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TOWSON NURSING HOME</u>		d. STREET ADDRESS <u>504 N. PATTERSON PK. AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA V. SCHUBERT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 12, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BRIGGS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH THORNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Florence Utz</u> Address <u>31 Elmore Ave. (13)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>59</u> , to <u>4/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>59</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.		ADDRESS (Street, city or town, state) <u>6805 York Rd. Baltimore 12 Md.</u> DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>4/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>	
22d. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u>2334 Jefferson St.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		MARRIAGE <i>John Doe</i>	
AGE <i>45</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>Jan 15 1900</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>Jan 15 1945</i>		PLACE OF DEATH <i>Home</i>	
TIME OF DEATH <i>10:30 AM</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1945</i>		DATE OF SIGNATURE <i>Jan 15 1945</i>	
PLACE OF SIGNATURE <i>St. Louis, Mo.</i>		PLACE OF SIGNATURE <i>St. Louis, Mo.</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1945</i>		DATE OF SIGNATURE <i>Jan 15 1945</i>	
PLACE OF SIGNATURE <i>St. Louis, Mo.</i>		PLACE OF SIGNATURE <i>St. Louis, Mo.</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1945</i>		DATE OF SIGNATURE <i>Jan 15 1945</i>	
PLACE OF SIGNATURE <i>St. Louis, Mo.</i>		PLACE OF SIGNATURE <i>St. Louis, Mo.</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
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VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4075

CERTIFICATE OF DEATH

04061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>B</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3V01-4</i> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>		d. STREET ADDRESS <i>10 Tamworth Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Charlotte H. Scott</i>		4. DATE OF DEATH Month Day Year <i>4-1-1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29, 1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Denah Dirschner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Walter Scott</i>		Address <i>3501 Carsdale Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arterio Sclerosis</i> DUE TO <i>334X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Repeated attacks of apoplexy</i> DUE TO <i>Arteriosclerosis</i> (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January, 1956</i> , to <i>April 1st 1959</i> , that I last saw the deceased alive on <i>April 1st</i> , 19 <i>59</i> , and that death occurred at <i>4:15</i> P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>M Paul Byerly</i> M.D. <i>303 3 W North Ave</i>		PHYSICIAN'S NAME (Type) <i>M Paul Byerly</i> <i>Balto 16 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. J. Ruck, Inc. 5305 Harford Rd. #14</i>		24a. REC'D BY REGISTRAR <i>APR 6 '59</i> DATE 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

STATE DEPARTMENT OF HEALTH—BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4076

CERTIFICATE OF DEATH

04062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle F Last SEDGWICK		4. DATE OF DEATH Month APRIL Day 26 Year 19 59	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 1, 1891
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOT BLACK		10b. KIND OF BUSINESS OR INDUSTRY SHOE SHINE PARLOR	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SEDGWICK		14. MOTHER'S MAIDEN NAME ELLA BLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 212-24-8673	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT FEMORAL ARTERY 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIOVASCULAR DISEASE. POLYCYSTIC KIDNEYS.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21 , 19 59 , to April 26 , 19 59 , and that death occurred at 9:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen Toms, M.D. M.D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 4/26/59	
PHYSICIAN'S NAME (Type) STEPHEN TOMS, M. D.		VAH, Fort Howard, Maryland 4/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson Funeral Home, Balto. Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

04063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN TB <u>5 yrs</u>		21-12-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>309 Prince St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Wallace</u> Middle <u>Senkbeil</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-51</u>
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert Senkbeil</u>		14. MOTHER'S MAIDEN NAME <u>Irene Marie Banks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Rosewood chart</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Microcephaly</u> (c) <u>Subdural Hematoma</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-24</u> , 19 <u>59</u> , to <u>4-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>59</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. <u>George C. Dineen</u> M.D. <u>Rosewood</u> ACTUAL SIGNATURE ADDRESS (Street, city or town, state) <u>4-25-59</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00003

CERTIFICATE OF DEATH

1903

1903

1903

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

[Faint text at the bottom of the page, possibly a signature line or official stamp.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04064

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calonsville</i>		c. LENGTH OF STAY IN 1b <i>5 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calonsville 29</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5305 Old Frederick Rd</i>			d. STREET ADDRESS <i>5305 Old Frederick</i>		
3. NAME OF DECEASED (Type or print) <i>CHARLES EDW. SHIPLEY</i>			4. DATE OF DEATH Month <i>4</i> Day <i>29</i> Year <i>1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/28/93</i>		9. AGE (In years last birthday) <i>65</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Balto. Co. Public Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles E. Shipley</i>			14. MOTHER'S MAIDEN NAME <i>Edwin</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WW 1</i>		17. INFORMANT <i>Olivia Hampton (sister)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Acute cardiac failure</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular</i>					
(c) <i>Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>4-29-59</i>	
EXAMINER'S NAME (Type) <i>GEO. S. M. KIEFFER, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/2/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>M. E. Church</i>	
22d. LOCATION (City, town, or county) <i>Calonsville</i>		22e. (State) <i>Md.</i>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don 28</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 4 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE TO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: 10/15/1968

5. Place of death: Home

6. Cause of death: Myocardial infarction

7. Manner of death: Natural

8. Signature of medical examiner: [Signature]

9. Date of certification: 10/16/1968

10. Office of medical examiner: Baltimore, Maryland

4079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE, Carroll Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 06X-2	
3. NAME OF DECEASED (Type or print) First GRACE Middle FROST Last SHIPLEY		4. DATE OF DEATH Month APRIL Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S	
13. FATHER'S NAME ALBERT E. SHIPLEY		14. MOTHER'S MAIDEN NAME MARY FROST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardio Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 days 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-24, 1948 , to 4-13, 1959 , that I last saw the deceased alive on 4-13, 1959 , and that death occurred at 6:22 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Hues		ADDRESS (Street, city or town, state) DATE SIGNED Cockeysville, Md 4/13/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-16-59	22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	22d. LOCATION (City, town, or county) (State) Howard County, Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 15 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hues

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal of the body.

DATE OF DEATH JAN 10 1950		PLACE OF DEATH HOME	
DECEASED JOHN J. JONES		MARRIAGE MARRIED	
CITY OF DEATH BALTIMORE		COUNTY OF DEATH BALTIMORE	
SEX MALE		RACE WHITE	
AGE 45		DATE OF BIRTH JAN 10 1905	
EDUCATION HIGH SCHOOL		OCCUPATION CLERK	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		UNDERLYING CAUSE OF DEATH HYPERTENSION	
DATE OF EXAMINATION JAN 10 1950		PLACE OF EXAMINATION HOME	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF DEATH REGISTRAR J. J. JONES	
DATE OF DEATH JAN 10 1950		PLACE OF DEATH HOME	
DECEASED JOHN J. JONES		MARRIAGE MARRIED	
CITY OF DEATH BALTIMORE		COUNTY OF DEATH BALTIMORE	
SEX MALE		RACE WHITE	
AGE 45		DATE OF BIRTH JAN 10 1905	
EDUCATION HIGH SCHOOL		OCCUPATION CLERK	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		UNDERLYING CAUSE OF DEATH HYPERTENSION	
DATE OF EXAMINATION JAN 10 1950		PLACE OF EXAMINATION HOME	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF DEATH REGISTRAR J. J. JONES	

1

RECEIVED JAN 10 1950

DEATH REGISTRAR

JOHN J. JONES

1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4080

CERTIFICATE OF DEATH

04066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>23 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville 8, Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>207 Sudbrook Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Ella Shipley</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1900</u>		9. AGE (In years last birthday) yrs. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Rev. Caleb M. Yost</u>			14. MOTHER'S MAIDEN NAME <u>Ella Hanna</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. E. Glen Shipley, 207 Sudbrook Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170x Metastatic Ca. of lungs</u> DUE TO (b) <u>Cancer of Right Breast</u> DUE TO (c) <u>1 yr.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>Dec. 7th, 1958</u> to <u>April 9th, 1959</u> , that I last saw the deceased alive on <u>April 8th, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James A. Miller M.D.</u>		ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd Pikesville - Md.</u>		DATE SIGNED <u>4/10/59</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Hensel</u>		ADDRESS <u>Pikesville 8, Md.</u>		24b. REC'D BY REGISTRAR <u>APR 13 '59</u>	24c. REGISTRAR'S SIGNATURE <u>Curtis S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4081

CERTIFICATE OF DEATH

04067
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2mth10dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle Last <u>Sipes</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ephriam Sipes</u>				14. MOTHER'S MAIDEN NAME <u>Unknown FRYFOGEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>year</u> <u>year</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 20, 19 59</u> to <u>April 21, 19 59</u> that I last saw the deceased alive on <u>April 21, 1959</u> and that death occurred at <u>6:45p</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>4-21-59</u>							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.				PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>4/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	
22d. LOCATION (City, town, or county) (State) <u>Randallstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 27 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4082

CERTIFICATE OF DEATH

04068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lena Skabisky</u>		4. DATE OF DEATH <u>April 30 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Mazel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Dr. Edward J. Skabisky</u>		Address <u>713 Rd. Wicklow</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 28, 1959</u> , to <u>April 30, 1959</u> , that I last saw the deceased alive on <u>April 29, 1959</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Justinas Kudirka</u> M.D.		ADDRESS (Street, city or town, state) <u>2151 W. Kenans Ave</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA</u>		<u>Baltimore 23 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) <u>4430 Belair Rd</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Cowanston</u>		ADDRESS <u>196 Hollins St.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE _____	
DATE <u>MAY 1 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04069

Reg. Dist. No.

3932

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk 22											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Cleveland Avenue				d. STREET ADDRESS 1 214 Cleveland Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First PEARL Middle LEE Last SOWARDS				4. DATE OF DEATH Month April Day 8th Year 1959											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1881		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Dana Sowards Address same as #2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Rt Hip, Arthritis										INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 4, 1959 , to 8 Apr. 1959 , that I last saw the deceased alive on 8 Apr. 1959 , and that death occurred at 1:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Kinship Road DATE SIGNED W. H. Morrison ACTUAL SIGNATURE W. H. Morrison M.D. 3 Kinship Road PHYSICIAN'S NAME (Type) W. Herbert Morrison, M.D. Baltimore 22, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/11/59		22c. NAME OF CEMETERY OR CREMATORY BelAir Memorial Gardens				22d. LOCATION (City, town, or county) (State) BelAir, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooke Bradley, Inc.						ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '59		24b. REGISTRAR'S SIGNATURE W. H. S. Howard					

01609

CERTIFICATE OF DEATH

2232

PLACE OF DEATH Baltimore		COUNTY Baltimore	
NAME OF DECEASED William		SEX Male	
DATE OF DEATH 1919		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH Baltimore		AGE 25	
OCCUPATION Clerk		CAUSE OF DEATH Typhoid	
PLACE OF DEATH Baltimore		COUNTY Baltimore	
NAME OF DECEASED William		SEX Male	
DATE OF DEATH 1919		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH Baltimore		AGE 25	
OCCUPATION Clerk		CAUSE OF DEATH Typhoid	

This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the State Department of Health. It is to be filled out in duplicate, one copy to be retained in the office of the Registrar, and the other copy to be retained in the office of the attending physician or the coroner.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4083

CERTIFICATE OF DEATH

04070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IZZY</u> Middle <u>✓</u> Last <u>SPERBER</u>				4. DATE OF DEATH Month <u>4-</u> Day <u>23-</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-1918</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Sperber</u>				14. MOTHER'S MAIDEN NAME <u>Rifka</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>084-14-8021</u>			
17. INFORMANT <u>Max Silverstein</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>163X</u> DUE TO (c) <u>163X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-10-1955</u> to <u>4-23-1959</u> , that I last saw the deceased alive on <u>4-21-1959</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. Stanley Cohen</u> M.D.				ADDRESS (Street, city or town, state) <u>7306 Liberty Rd Balto Md</u>			
PHYSICIAN'S NAME (Type) <u>B. STANLEY COHEN</u>				DATE SIGNED <u>4-23-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosenhaym Hebrew</u>	
22d. LOCATION (City, town, or county) (State) <u>Rosenhaym Md</u>				22e. (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levine</u> ADDRESS <u>2100 Canton Place</u>				24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4084

CERTIFICATE OF DEATH

04071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Arm	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home of Maryland		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First ELEANOR Middle ALVERTA Last STANDIFORD		4. DATE OF DEATH Month APRIL Day 20, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1870
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY school teacher	11. BIRTHPLACE (State or foreign country) Glen Arm, Md.
13. FATHER'S NAME Richard C. Francis		14. MOTHER'S MAIDEN NAME Eleanor Stover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records-Prsbyterian Home of Md. Toswon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OBSTRUCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1958 , to APRIL 20, 1959 , that I last saw the deceased alive on APRIL 16, 1959 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. J. Venable, Jr.		ADDRESS (Street, city or town, state) 7215 York Road	
PHYSICIAN'S NAME (Type) S. J. Venable, Jr. M.D.		DATE SIGNED 2/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1959	22c. NAME OF CEMETERY OR CREMATORY Waugh Chapel
22d. LOCATION (City, town, or county) Glen Arm,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John C. Kennedy		Male		45		Jan 1, 1920		New York City		Jan 15, 1965		New York City		Heart disease		Natural		John C. Kennedy		John C. Kennedy		John C. Kennedy	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of report		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
John C. Kennedy		Son		1234 Main St.		New York		NY		10001		Jan 16, 1965		John C. Kennedy		Registrar		New York City		212-1234-5678		212-1234-5679	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS, NEW YORK CITY, NEW YORK.

NEW YORK CITY, NEW YORK

1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04072

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Sparrowspoint Balto county MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN life Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 vol-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrowspoint hospital			d. STREET ADDRESS 3103 Brightonst # 16		
3. NAME OF DECEASED (Type or print) Walter Middle Stanley			4. DATE OF DEATH Month April Day 20 Year 1959		
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 16-1909	9. AGE (In years last birthday) 50 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) Dorchester County Md.	
13. FATHER'S NAME Asbury Stanley			14. MOTHER'S MAIDEN NAME Martha Clark		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Martha Stanley Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 812X CRUSHING INJURY TO SKULL C DUE TO (b) Compound fracture of ALL SKULL DUE TO (c) Bones Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH J
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) TRUCK knocked him down + backed over head			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 6.15 4-20 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory - BSCa Baltimore # 19 BALTO Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/20/59	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-59		22c. NAME OF CEMETERY OR CREMATORY Taylorss Island Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. M. St Clair - Cambridge Md.		24a. REGISTERAR'S SIGNATURE APR 22 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE
BALTIMORE
HEALTH DEPARTMENT
RECEIVED
JAN 10 1918

NAME OF DECEASED JAMES H. HARRIS		AGE 45	
SEX Male		RACE White	
DATE OF DEATH Jan 10 1918		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DISEASE OR INJURY Coronary Artery Disease		PREVIOUS ILLNESS None	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		TREATMENT None	
FINDINGS AT AUTOPSY Coronary Artery Disease		OPINION OF EXAMINER Natural	
SIGNATURE OF EXAMINER J. H. Harris		DATE Jan 10 1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4086

CERTIFICATE OF DEATH

04073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 430 Ingleside Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE B. STANSBURY		4. DATE OF DEATH Month Day Year April 4. 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14. 1870
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk, retired 18 years		10b. KIND OF BUSINESS OR INDUSTRY Baltimore County Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Standbury		14. MOTHER'S MAIDEN NAME Lucinda Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-09-4754	
17. INFORMANT Margaret Gartner		Address 430 Ingleside Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Acute DUE TO Hypertensive Cardiovascular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Myocardial Infarction (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 5 months Year Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 to April 4, 1959 , that I last saw the deceased alive on March 28, 1959 , and that death occurred at 6:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Fearing		ADDRESS (Street, city or town, state) 3025 Belair Road	
DATE SIGNED 4-6-59			
PHYSICIAN'S NAME (Type) William L. Fearing		3025 Belair Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

00073

CERTIFICATE OF DEATH

0008

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

THE STATE OF MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE COUNTY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4087

CERTIFICATE OF DEATH

04074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 18 Dixie Drive				d. STREET ADDRESS/ 18 Dixie Drive #4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) KATHRYN W. STEADMAN				4. DATE OF DEATH April 28 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Ellwood M. Wellener			
14. MOTHER'S MAIDEN NAME Sarah Jane Evans				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Mr. Richard L. Steadman-18 Dixie Drive #4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholestasis							INTERVAL BETWEEN ONSET AND DEATH 1 hour
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 22, 19 59 , to April 28, 19 59 , that I last saw the deceased alive on April 27, 19 59 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Richard Frankel M.D. 705 Madison Ave Bldg Baltimore 1, Md				DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Balto-17, Md.				24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



4088

CERTIFICATE OF DEATH

04075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 208 Second Ave. Marley Rd	
3. NAME OF DECEASED (Type or print) Norah W. STEIN		4. DATE OF DEATH Month 4 Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME James WRIGHT		14. MOTHER'S MAIDEN NAME Ellen WITHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 12, 1957 , to Apr. 21, 1959 , that I last saw the deceased alive on Apr. 21, 1959 , and that death occurred at 11:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE STELLA WACHSLER M.D.		ADDRESS (Street, city or town, state) Spring Grove St. H.	
PHYSICIAN'S NAME (Type) Stella Wachslers		DATE SIGNED 4/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 24, 1959	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	22d. LOCATION (City, town, or county) (State) Parkville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE PT. Singlet		24a. RECORD BY REGISTRAR APR 24 1959	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bengies				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bengies			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 14 Box 477 Carroll Island Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mollie First STOPCKER Last STOPCKER				4. DATE OF DEATH April Month 9 Day 1959 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		IF UNDER 24 HRS. Months 9 Days 9 Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown Lubba				14. MOTHER'S MAIDEN NAME Unknown Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Margaret Wilkinson Rt. 14 Box 477	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1959 to April 9, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 4/9/59 ACTUAL SIGNATURE M. Baumgardner M.D. 4/9/59 PHYSICIAN'S NAME (Type) M. Baumgardner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lassahn Funeral Home 7401 Belair Rd				24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04076

CERTIFICATE OF DEATH

4083

14

1. NAME OF DECEASED MORRIS, ALICE		2. SEX F		3. AGE 78		4. DATE OF BIRTH JAN 15 1886		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION HOUSEWIFE	
7. MARITAL STATUS MARRIED		8. NAME OF SPOUSE JOHN MORRIS		9. DATE OF MARRIAGE JUN 15 1905		10. PLACE OF MARRIAGE BALTIMORE, MARYLAND		11. NAME OF DECEASED'S FATHER JOHN MORRIS		12. NAME OF DECEASED'S MOTHER MARY MORRIS	
13. DATE OF DEATH JAN 15 1964		14. TIME OF DEATH 10:30 AM		15. PLACE OF DEATH HOME		16. CAUSE OF DEATH HEART DISEASE		17. MANNER OF DEATH NATURAL		18. SIGNATURE OF PHYSICIAN J. H. MORRIS	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE JOHN MORRIS		20. SIGNATURE OF DECEASED'S NEXT OF KIN JOHN MORRIS		21. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL J. H. MORRIS		22. SIGNATURE OF DECEASED'S CHURCH CLERK J. H. MORRIS		23. SIGNATURE OF DECEASED'S BURIAL CLERK J. H. MORRIS		24. SIGNATURE OF DECEASED'S FUNERAL HOME CLERK J. H. MORRIS	
25. SIGNATURE OF DECEASED'S BURIAL CLERK J. H. MORRIS		26. SIGNATURE OF DECEASED'S FUNERAL HOME CLERK J. H. MORRIS		27. SIGNATURE OF DECEASED'S BURIAL CLERK J. H. MORRIS		28. SIGNATURE OF DECEASED'S FUNERAL HOME CLERK J. H. MORRIS		29. SIGNATURE OF DECEASED'S BURIAL CLERK J. H. MORRIS		30. SIGNATURE OF DECEASED'S FUNERAL HOME CLERK J. H. MORRIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4090

CERTIFICATE OF DEATH

04077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle M. Last STRAUSS				4. DATE OF DEATH Month April Day 18 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1876	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) N.J.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Christian H. Hoffrogge			
14. MOTHER'S MAIDEN NAME Mary Louise Dill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Mr. C. H. Hoffrogge - 516 Old Orchard Rd. #29			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Anterograde hypertensive cardiovascular disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1949 , 19____, to 18 April 1959 , that I last saw the deceased alive on 18 April , 19 59 , and that death occurred at 10:04 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2, Maryland DATE SIGNED 4-20-59							
ACTUAL SIGNATURE John A. Nesbitt, Jr.				M.D. 1118 St Paul St Baltimore 2, Maryland			
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 4/21/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Son - Balto 17, Md.				24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Haus	

1992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G242,5-8-59 md

CERTIFICATE OF DEATH

04078

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS 112 Hopkins Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle HARDAWAY Last STRICKLAND				4. DATE OF DEATH Month April Day 26 , 1959 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1891		9. AGE (In years on birthday) 68 yrs.	IF UNDER 1 YEAR Months 08 Days 07
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman—retired		10b. KIND OF BUSINESS OR INDUSTRY Machinery Mfg. Co.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Strickland				14. MOTHER'S MAIDEN NAME Martha Hardaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Address E. Starr Coale, 112 Hopkins Rd., Balto. 12, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2-3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema, Cirrhosis Liver							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3/12 , 19 59 , to April 26 , 19 59 , that I last saw the deceased alive on April 25 , 19 59 , and that death occurred at 1:30 P .M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4-E-33rd St Balto 18 md DATE SIGNED April 29 1959							
ACTUAL SIGNATURE Newland E. Day M.D. 4-E-33rd St Balto 18 md							
PHYSICIAN'S NAME (Type) NEWLAND E. DAY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1959		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4092

CERTIFICATE OF DEATH

Reg. Dist. No.

04079

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 Sheridan Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>E.</u> Last <u>SUTER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 12, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self emp</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Rufus W. Suter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Spanish Am.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. John R. Suter</u>		Address <u>5602 Narcissus Ave. Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INSUFFICIENCY</u> DUE TO (c) <u>ARTERIO-SCLEROTIC C.V. D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2 days</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2017 LIBERTY ROAD</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Harold H. Weinberg</u> M.D. <u>2017 LIBERTY ROAD</u>		PHYSICIAN'S NAME (Type) <u>HAROLD H. WEINBERG MD</u> <u>RANDALLSTOWN MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam J. Pickens & Sons - Balto</u>		ADDRESS <u>17, 1st</u>	
24a. REC'D BY REGISTRAR <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

CERTIFICATE OF DEATH

4022

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE _____		TIME _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4093

CERTIFICATE OF DEATH

04080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3208 Spaul Court</u>		d. STREET ADDRESS <u>2011 Gough St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Stanley SZCZESZEK</u>		4. DATE OF DEATH Month Day Year <u>Apr. 18 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29 - 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sugar Refinery Distiller</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>SZCZESZEK</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>212-09-5944</u>	
		17. INFORMANT <u>Cecilia S. Szczech</u> Address <u>2011 Gough St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>203X</u> DUE TO <u>Coronary Occlusion.</u>		<u>Sudden</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma.</u>		<u>One year</u>	
(c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>58</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> M.D. <u>9005 Hartford Rd.</u>		DATE SIGNED <u>4/18/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK Jr.</u>		<u>BALTO 14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u> ADDRESS <u>2007 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 241 4-17-59
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4094

04081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN lb 54 Essex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 412 Back River Neck Rd.		d. STREET ADDRESS 412 Back River Neck Rd. (21)	
3. NAME OF DECEASED (Type or print) First EDWARD Middle TATUM Last TATUM		4. DATE OF DEATH Month April Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1907
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Detective Agency	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Tatum		14. MOTHER'S MAIDEN NAME Florence Burnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 043-05-0598	17. INFORMANT Bertha Tatum Address Same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Second and third degree burns 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon Monoxide Poisoning DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Burning of home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4/7 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Essex Balto Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. J. Ford		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/7/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/10/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski		ADDRESS 1407 Eastern Ave.	
24a. REC'D BY REGISTRAR DATE APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	



RECEIVED
JAN 10 1907
U.S. DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

4002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		AGE 45		SEX Male	
DATE OF DEATH Jan 10 1907		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		LOCALITY Baltimore	
MEDICAL HISTORY Patient had been ill for several days with chest pain and shortness of breath.		PREVIOUS ILLNESS None		TREATMENT None	
FINDINGS AT AUTOPSY Heart enlarged, coronary arteries atheromatous.		POST-MORTEM EXAMINATION None		LABORATORY EXAMINATION None	
SIGNATURE OF EXAMINER J. J. Jones		DATE Jan 10 1907		PLACE Baltimore	
OFFICE OF THE MEDICAL EXAMINER Baltimore, Md.		COUNTY Baltimore		STATE Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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Item 4, Film G241 4/16/59 for
4095
CERTIFICATE OF DEATH

04082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson d. STREET ADDRESS 1 407 Alabama Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winfield J. Taylor		4. DATE OF DEATH Month April Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1899
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR: Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Taylor		14. MOTHER'S MAIDEN NAME Bertha E. Kreidler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 100-30-2109	
17. INFORMANT Leland D. Taylor		Address 407 Alabama Rd. Towson 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 178x 1NANITION DUE TO (b) MULTIPLE METASTASES DUE TO (c) SEMINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 3 YEARS 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/13 , 19 59 , to 4/12 , 19 59 , that I last saw the deceased alive on 4/12 , 19 59 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald L. Somerville		ADDRESS (Street, city or town, state) 25 W. PA. AVE. Towson 4, Md	
DATE SIGNED 4/13/59			
PHYSICIAN'S NAME (Type) Donald L. Somerville, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59	
22c. NAME OF CEMETERY OR CREMATORY Arkport Cem		22d. LOCATION (City, town, or county) (State) Hornell, Steuben, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		ADDRESS 1050 York Rd. Towson 4	
24a. REC'D BY REGISTRAR APR 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4096

CERTIFICATE OF DEATH

04083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 7		c. LENGTH OF STAY IN 1b X Balto. 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3633 Eitemiller Rd.		d. STREET ADDRESS 3633 Eitemiller Rd.	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last TERRY		4. DATE OF DEATH Month April Day 28 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Konradi		14. MOTHER'S MAIDEN NAME Catherine --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Frank R. Terry - 3633 Eitemiller Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cerebral Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 to Apr 28, 1959 that I last saw the deceased alive on Apr 26, 1959 and that death occurred at 4:45 P.M. from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE Dr. Paul Byerly M.D. ADDRESS (Street, city or town, state) 3033 W. North A PHYSICIAN'S NAME (Type) Dr. Paul Byerly			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/59	
22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Viskner & Sons - Balto.		24a. REC'D BY REGISTRAR DATE APR 30 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
4097									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04084									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Marksworth Rd.					d. STREET ADDRESS 1002 Marksworth Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Them					4. DATE OF DEATH Month Day Year Apr. 21, 19 59				
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1865		9. AGE (In years last birthday) 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Bernal					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. INFORMANT				
					Address Mrs Mary Eszes, 1002 Marksworth Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease-senile degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Senility-age 94. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1957 , 19____, to April 21, 1959 , that I last saw the deceased alive on April 1, 1959 and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4008 Edmondson Ave. DATE SIGNED ACTUAL SIGNATURE William R. Johnson M.D. PHYSICIAN'S NAME (Type) William R. Johnson									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
22d. LOCATION (City, town, or county) (State) A.A. Co. Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.					24a. REC'D BY REGISTRAR DATE APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		



CERTIFICATE OF DEATH

10-11-1907

10-11-1907

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10-11-1907

4098

CERTIFICATE OF DEATH

04085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beaver Dam Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Ridgely Thompson				4. DATE OF DEATH 4-20-59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1888	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator				10b. KIND OF BUSINESS OR INDUSTRY tool mfg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tom Thompson				14. MOTHER'S MAIDEN NAME Mary Ann Knapp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-03-6943		17. INFORMANT Charles R.W. Thompson, Timonium, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyper tension DUE TO 2 yrs (c) Arteriosclerosis general - 5 yrs						INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 1-1-59 to 4-20-59 , that I last saw the deceased alive on 4-10-59 , and that death occurred at 8:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Saffell M.D.				DATE SIGNED 4-22-59			
PHYSICIAN'S NAME (Type) James G. Saffell				ADDRESS (Street, city or town, state) Reisterstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-59		22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah Brooks ADDRESS 622 York Rd., Towson 4, Md.				24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• *Review* 2001-2002

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4099
CERTIFICATE OF DEATH

04086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in The Pines 16 Fusting Ave		d. STREET ADDRESS 606 East 37th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Virginia Last Thompson		4. DATE OF DEATH Month April Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1868
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Debaugh		14. MOTHER'S MAIDEN NAME (unknown) Hubbard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel L. Meeks, 606 East 37th Street		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-23, 1959</u> , to <u>4-28, 1959</u> , that I last saw the deceased alive on <u>4-27, 1959</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Stanley Cohen</u>		ADDRESS (Street, city or town, state) <u>7306 Liberty Rd. Baltimore, Md.</u>	
DATE SIGNED <u>4-30-59</u>			
PHYSICIAN'S NAME (Type) B. Stanley Cohen			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-1-59	
22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		22d. LOCATION (City, town, or county) (State) Providence, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAY 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

4099

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

4098

DATE OF BIRTH

1. NAME OF DECEASED		2. SEX		3. RACE		4. AGE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4100

CERTIFICATE OF DEATH

04087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 40 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2631 Miles Avenue (11)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN M. THORPE		4. DATE OF DEATH Month April Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1900
9. AGE (In years last birthday) yrs. 59		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grinder		10b. KIND OF BUSINESS OR INDUSTRY Oil Burner Mfg. Co.	
11. BIRTHPLACE (State or foreign country) Harpers Ferry, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Thorpe		14. MOTHER'S MAIDEN NAME Virginia Bierly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE WITH SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY CALCIFICATION AND OCCLUSION, OLD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Carcinoma of bladder. 2. Myocardial infarction, old		INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to April 22 , 19 59 , that I last saw the deceased alive on April 22 , 19 59 , and that death occurred at 4:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) DATE SIGNED 4/23/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D., Acting Director Professional Services		M.D. VA HOSPITAL, FT. HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Rd., Balto. Md.	
24a. REGISTERED BY APR 27 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04088

4101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HEBBVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7523 WINDSOR MILL RD</u>				d. STREET ADDRESS <u>1 ST. LUKE'S LANE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>WINFIELD</u> Last <u>THURSBY</u>				4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1890</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARIAN THURSBY</u>				14. MOTHER'S MAIDEN NAME <u>AGNES OFFUTT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-30-7225</u>		17. INFORMANT <u>WIFE - MRS. LOTTIE THURSBY</u> Address <u>7523 WINDSOR MILL RD BALTO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA - COLON & METASTASES</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>59</u> , to <u>4/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>59</u> , and that death occurred at <u>3:45 A.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD BALTO. MD.</u>				DATE SIGNED <u>4/12/59</u>			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>							
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Apr. 15 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Phillis Lamoreau</u> ADDRESS <u>1003 W. Balt. St</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Edwin L. Pierpont</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102

CERTIFICATE OF DEATH

04089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN TB 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK B. TILTON SR.				4. DATE OF DEATH Month Day Year 4 - 12 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-91	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES TILTON				14. MOTHER'S MAIDEN NAME KATHERINE DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-094575		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG (ANAPLASTIC) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-6- , 19 59 to 4-12- , 19 59 , that I last saw the deceased alive on 4-12- , 19 59 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Newcomer				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.				DATE SIGNED 4-12-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balt.				24a. REC'D BY REGISTRAR DATE APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1000

Reg. Dist. No.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Brown		Male		45		Jan 15 1857		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocarditis		Chest Pain		Jan 10 1902		New York City	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		J. A. Smith	
Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Justice		Signature of Jury	
J. B. Jones		J. C. Smith		J. D. Brown		J. E. White		J. F. Green	

W

2

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 0241, 4/13/59

4103

CERTIFICATE OF DEATH

04090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1301 Rosewick Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALOYSIUS ALOIS LOUIS FRANK TOMASCHKO				4. DATE OF DEATH Month Day Year April 5, 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/1897		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret - tailor		10b. KIND OF BUSINESS OR INDUSTRY Excello Coat Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Tomaschko				14. MOTHER'S MAIDEN NAME Ernestine Glaser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Army-W.W.1		16. SOCIAL SECURITY NO.		17. INFORMANT Address Elizabeth Kiessling Tomaschko, wife, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO Arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 previous cerebral vascular accidents; Diabetes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Dr John Geldrich M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/59		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimmek ADDRESS 3331 Brehms Lane				24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text from bleed-through]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4104

CERTIFICATE OF DEATH

04091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>George</u> Last <u>Tweed</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/7/35</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Newark, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton R. Tweed</u>		14. MOTHER'S MAIDEN NAME <u>Sara May Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic broncho-pneumonia with abscess</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13/59</u> , 19 <u> </u> , to <u>4/13/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>4/13/59</u> , 19 <u> </u> , and that death occurred at <u>10:20 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Riedel, Pathologist</u> M.D.		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave</u> DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Riedel</u>		<u>Baltimore 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/16/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lewersville Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Bone</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

AMERICAN
BIRMINGHAM

Handwritten signature



1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 707 E. 30th Street	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE (NMI) WAGNER		4. DATE OF DEATH Month Day Year APRIL 14 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1890
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wagner		14. MOTHER'S MAIDEN NAME Barbara Arould	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO CHRONIC PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RIGHT NEPHRECTOMY DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH (c) MYOCARDIAL INFARCTION			
INTERVAL BETWEEN ONSET AND DEATH 4 Days Unknown 6 Days Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOSIS, MIDDLE CEREBRAL ARTERY, OLD, CHR. CHRONIC PULMONARY EMPHYSEMA.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 13, 1959 , to April 14, 1959 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE OTTO C. BEYER, M.D.		DATE SIGNED 4/14/59	
PHYSICIAN'S NAME (Type) OTTO C. BEYER, M.D.		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) 4430 Belair Rd. Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Rd. Baltimore, Md.		24a. REC'D BY REGISTRAR APR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hays			

VS A15 (4)
ISM 10/57

14008

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

1102

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1875		Maryland		Baltimore		Maryland		United States	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED		OTHER	
White		White		Roman Catholic		Married		Single		Widow		Divorced		Other	
EDUCATION		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH		HOUR OF DEATH		DAY OF DEATH	
High School		Carpenter		Heart Disease		3 Months		Home		April 10, 1941		10:00 AM		April 10, 1941	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS DISEASES		PREVIOUS INJURIES		PREVIOUS TRAUMAS		PREVIOUS ACCIDENTS		PREVIOUS POISONS		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS DEATHS		PREVIOUS BURIALS		PREVIOUS CREMATIONS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS	
None		None		None		None		None		None		None		None	
PREVIOUS DEATHS		PREVIOUS BURIALS		PREVIOUS CREMATIONS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS		PREVIOUS OTHERS	
None		None		None		None		None		None		None		None	

RECEIVED FROM

APR 11 1941

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3209 Texas Avenue</i>		d. STREET ADDRESS <i>3209 Texas Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Birdie Viola Wareheim</i>		4. DATE OF DEATH Month Day Year <i>April 10th 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 15, 1874</i>
9. AGE (In years lost birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Samuel Hoffacker</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Caltrider</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Charles Vavrina</i>		Address <i>3209 Texas Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 da.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized cerebral arteriosclerosis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 1958</i> , to <i>April 1959</i> , that I last saw the deceased alive on <i>April 10, 1959</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>8100 Harford Rd.</i>		DATE SIGNED <i>4-11-59</i>	
ACTUAL SIGNATURE <i>S. Elliot Harris</i>		M.D. <i>Baltimore</i>	
PHYSICIAN'S NAME (Type) <i>S. Elliot Harris</i>			
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/13/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Trinity Reformed</i>	22d. LOCATION (City, town, or county) (State) <i>Manchester, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN TB 3 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 S. Prospect Ave.				d. STREET ADDRESS 101 S. Prospect Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THEODORE WEBSTER				4. DATE OF DEATH Month April Day 2 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1877	
9. AGE (In years last birthday) 82 1/2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 59		11. IF UNDER 24 HRS. Months 2 Days 1 Hours 59		12. IF UNDER 24 HRS. Months 2 Days 1 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY Cecil Co., Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME William Webster				14. MOTHER'S MAIDEN NAME Haines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Florence F. Yarish-856 W. 37th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO Arteriosclerosis cardiovascular disease (c) 15 yrs							INTERVAL BETWEEN ONSET AND DEATH 6 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 April, 1959 , to 2 April, 1959 , that I last saw the deceased alive on 2 April, 1959 , and that death occurred at 6 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Rowe				ADDRESS (Street, city or town, state) 715 Frederick Ave Baltimore			
PHYSICIAN'S NAME (Type) James E. Rowe				DATE SIGNED 4/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/1959		22c. NAME OF CEMETERY OR CREMATORY Govan's Presbyterian Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR Arthur S. Krause			
ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.				24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BY

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4108

CERTIFICATE OF DEATH

04095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balta</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>35 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 E. Overlea Ave</u>		d. STREET ADDRESS <u>18 E. Overlea Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>G.</u> Last <u>Weger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For out man for tables.</u>	
11. BIRTHPLACE (State or foreign country) <u>BaHo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George K. Weger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Funk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-4158</u>	
17. INFORMANT <u>Catherine F. Weger</u> Address <u>18 E. Overlea Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 1948</u> , to <u>APRIL 9, 1959</u> , that I last saw the deceased alive on <u>APRIL 2, 1959</u> , and that death occurred at <u>11:AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Glean G. Lewis</u> M.D. <u>6232 Belair Road</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ADAM G. SWISS</u>		<u>BALTIMORE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Balta Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wippel Bros. 7110 Belair Rd.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal of the body.

01008

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

01008

ACCIDENT

WILLIAM

WILLIAM

DATE

TIME

PLACE

CAUSE

MANNER

SEX

AGE

HEIGHT

WEIGHT

HAIR

EYES

SKIN

TEETH

NOSE

EARS

THROAT

TRACHEA

ESOPHAGUS

STOMACH

INTESTINES

BLADDER

RECTUM

PROSTATE

UTERUS

VAGINA

PELVIS

PERINEUM

ANUS

SCROTUM

TESTES

EPIDIDYMIS

SEMEN

SPERMATID

SPERMATOZOA

OVUM

EMBRYO

FETUS

PLACENTA

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PERITONEUM

DIAPHRAGM

STERNUM

RIBS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr5mth16dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville, Maryland 16-15-2	
d. STREET ADDRESS 3546 Madison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olof Middle Bruno Last Wessberg		4. DATE OF DEATH Month April Day 7 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bricklayer		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Olof Wessberg		14. MOTHER'S MAIDEN NAME Greta? (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 578-01-7397	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to Bronchial obstruction due to DUE TO regurgitated gastric contents PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic cardiac vascular disease			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) injuries from choking	
20c. TIME OF INJURY Month, Day, Year Hour o. m. April 7 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville Ball m		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers to Mrs. 1400 Chapin St NW Wash 9		ADDRESS 4412	
24a. REC'D BY REGISTRAR APR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

41086

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

41086

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15, 1925		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. OCCUPATION Carpenter		8. CAUSE OF DEATH Myocardial Infarction		9. MANNER OF DEATH Natural	
10. SIGNATURE OF EXAMINER J. H. Smith		11. SIGNATURE OF WITNESSES J. H. Smith		12. SIGNATURE OF CORONER J. H. Smith	
13. SIGNATURE OF DECEASED J. H. Smith		14. SIGNATURE OF NEXT OF KIN J. H. Smith		15. SIGNATURE OF CLERK J. H. Smith	
16. SIGNATURE OF JURY J. H. Smith		17. SIGNATURE OF JURY J. H. Smith		18. SIGNATURE OF JURY J. H. Smith	
19. SIGNATURE OF JURY J. H. Smith		20. SIGNATURE OF JURY J. H. Smith		21. SIGNATURE OF JURY J. H. Smith	
22. SIGNATURE OF JURY J. H. Smith		23. SIGNATURE OF JURY J. H. Smith		24. SIGNATURE OF JURY J. H. Smith	
25. SIGNATURE OF JURY J. H. Smith		26. SIGNATURE OF JURY J. H. Smith		27. SIGNATURE OF JURY J. H. Smith	
28. SIGNATURE OF JURY J. H. Smith		29. SIGNATURE OF JURY J. H. Smith		30. SIGNATURE OF JURY J. H. Smith	
31. SIGNATURE OF JURY J. H. Smith		32. SIGNATURE OF JURY J. H. Smith		33. SIGNATURE OF JURY J. H. Smith	
34. SIGNATURE OF JURY J. H. Smith		35. SIGNATURE OF JURY J. H. Smith		36. SIGNATURE OF JURY J. H. Smith	
37. SIGNATURE OF JURY J. H. Smith		38. SIGNATURE OF JURY J. H. Smith		39. SIGNATURE OF JURY J. H. Smith	
40. SIGNATURE OF JURY J. H. Smith		41. SIGNATURE OF JURY J. H. Smith		42. SIGNATURE OF JURY J. H. Smith	
43. SIGNATURE OF JURY J. H. Smith		44. SIGNATURE OF JURY J. H. Smith		45. SIGNATURE OF JURY J. H. Smith	
46. SIGNATURE OF JURY J. H. Smith		47. SIGNATURE OF JURY J. H. Smith		48. SIGNATURE OF JURY J. H. Smith	
49. SIGNATURE OF JURY J. H. Smith		50. SIGNATURE OF JURY J. H. Smith		51. SIGNATURE OF JURY J. H. Smith	
52. SIGNATURE OF JURY J. H. Smith		53. SIGNATURE OF JURY J. H. Smith		54. SIGNATURE OF JURY J. H. Smith	
55. SIGNATURE OF JURY J. H. Smith		56. SIGNATURE OF JURY J. H. Smith		57. SIGNATURE OF JURY J. H. Smith	
58. SIGNATURE OF JURY J. H. Smith		59. SIGNATURE OF JURY J. H. Smith		60. SIGNATURE OF JURY J. H. Smith	
61. SIGNATURE OF JURY J. H. Smith		62. SIGNATURE OF JURY J. H. Smith		63. SIGNATURE OF JURY J. H. Smith	
64. SIGNATURE OF JURY J. H. Smith		65. SIGNATURE OF JURY J. H. Smith		66. SIGNATURE OF JURY J. H. Smith	
67. SIGNATURE OF JURY J. H. Smith		68. SIGNATURE OF JURY J. H. Smith		69. SIGNATURE OF JURY J. H. Smith	
70. SIGNATURE OF JURY J. H. Smith		71. SIGNATURE OF JURY J. H. Smith		72. SIGNATURE OF JURY J. H. Smith	
73. SIGNATURE OF JURY J. H. Smith		74. SIGNATURE OF JURY J. H. Smith		75. SIGNATURE OF JURY J. H. Smith	
76. SIGNATURE OF JURY J. H. Smith		77. SIGNATURE OF JURY J. H. Smith		78. SIGNATURE OF JURY J. H. Smith	
79. SIGNATURE OF JURY J. H. Smith		80. SIGNATURE OF JURY J. H. Smith		81. SIGNATURE OF JURY J. H. Smith	
82. SIGNATURE OF JURY J. H. Smith		83. SIGNATURE OF JURY J. H. Smith		84. SIGNATURE OF JURY J. H. Smith	
85. SIGNATURE OF JURY J. H. Smith		86. SIGNATURE OF JURY J. H. Smith		87. SIGNATURE OF JURY J. H. Smith	
88. SIGNATURE OF JURY J. H. Smith		89. SIGNATURE OF JURY J. H. Smith		90. SIGNATURE OF JURY J. H. Smith	
91. SIGNATURE OF JURY J. H. Smith		92. SIGNATURE OF JURY J. H. Smith		93. SIGNATURE OF JURY J. H. Smith	
94. SIGNATURE OF JURY J. H. Smith		95. SIGNATURE OF JURY J. H. Smith		96. SIGNATURE OF JURY J. H. Smith	
97. SIGNATURE OF JURY J. H. Smith		98. SIGNATURE OF JURY J. H. Smith		99. SIGNATURE OF JURY J. H. Smith	
100. SIGNATURE OF JURY J. H. Smith		101. SIGNATURE OF JURY J. H. Smith		102. SIGNATURE OF JURY J. H. Smith	

ORIGINAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04097
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> rural- Baltimore	
c. LENGTH OF STAY IN 1b 7yrs		d. STREET ADDRESS 2316 Miller Ave 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LINA V WHEELER		4. DATE OF DEATH Month Apr Day 19 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Feb 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Imhoff.		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Gordon Wheeler 2316 Miller Av		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular Disease (c) Atherosclerosis</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH inst undet undet</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle MD		DATE SIGNED 4-19-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-59	
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WOODLAWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan		ADDRESS 3818 Roland Ave	
24a. REC'D BY REGISTRAR APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hane	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH 1910		PLACE OF DEATH BALTIMORE	
NAME OF DECEASED John S. White		SEX Male	
AGE 45		RACE White	
OCCUPATION Teacher		MANNER OF DEATH Natural	
CAUSE OF DEATH Heart Disease		DISEASES PRESENT Hypertensive Cardiovascular Disease	
DATE OF EXAMINATION July 10, 1910		PLACE OF EXAMINATION Home	
SIGNATURE OF EXAMINER [Signature]		DATE OF SIGNATURE July 10, 1910	
LOCAL HEALTH OFFICER [Signature]		DATE OF SIGNATURE July 10, 1910	
COUNTY CLERK [Signature]		DATE OF SIGNATURE July 10, 1910	
CITY CLERK [Signature]		DATE OF SIGNATURE July 10, 1910	
STATE CLERK [Signature]		DATE OF SIGNATURE July 10, 1910	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4111

CERTIFICATE OF DEATH

04098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glyndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowers Lane		d. STREET ADDRESS Bowers Lane	
3. NAME OF DECEASED (Type or print) First Middle Last George Washington Whitcomb		4. DATE OF DEATH Month Day Year April 27, 1959 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1889
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Whitcomb		14. MOTHER'S MAIDEN NAME Elizabeth Bussler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Yes W.W.I		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. L.C. Marie Whitcomb, Glyndon, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Atherosclerosis - general myocardium - degenerative		INTERVAL BETWEEN ONSET AND DEATH 2 days years 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1930 to 4-26-59 , that I last saw the deceased alive on 4-26-59 , 19 59 , and that death occurred at 2:30 A.M. from the causes (and on the date stated above). ADDRESS (Street, city or town, state) DATE SIGNED Reisterstown Md 4-27-59			
ACTUAL SIGNATURE James G. Saffell M.D.		PHYSICIAN'S NAME (Type) James G. Saffell Md Reisterstown Md 4-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29/59	
22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4112

CERTIFICATE OF DEATH

04099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3555 FLANNERY LANE</u>				d. STREET ADDRESS <u>3555 Flannery Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>LEONIA</u> Middle <u>ADELE</u> Last <u>WICKS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 5, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. MYERS</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. SHERIFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-16-6010</u>		17. INFORMANT <u>DAUGHTER - MRS. VERNON HICK</u> Address <u>8028 LIBERTY RD. BALTO. 7, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS & CARCINOMA</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>70 YRS.</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>JUNE 14, 1954</u> to <u>APRIL 1, 1959</u> , that I last saw the deceased alive on <u>MARCH 30, 1959</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D. <u>8204 LIBERTY RD.</u>				DATE SIGNED <u>4/1/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u>				<u>BALTO. 7, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto. 17, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christian S. Thoms</u>	

CERTIFICATE OF DEATH

1113

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH Jan 15, 1900</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE Jan 1, 1925</p>	
<p>9. NAME OF SPOUSE Jane Doe</p>		<p>10. DATE OF DEATH Feb 10, 1945</p>	
<p>11. PLACE OF DEATH Baltimore, Md.</p>		<p>12. CAUSE OF DEATH Heart Disease</p>	
<p>13. MEDICAL HISTORY Hypertension, Diabetes</p>		<p>14. PRESENT ILLNESS Angina Pectoris</p>	
<p>15. TREATMENT Medical</p>		<p>16. SIGNATURE OF PHYSICIAN Dr. J. K. Smith</p>	
<p>17. SIGNATURE OF REGISTRAR J. L. Brown</p>		<p>18. DATE Feb 10, 1945</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

3938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 Arbutus</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1244 Birch Ave.</i>		d. STREET ADDRESS <i>1244 Birch Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Ida M. Wiegard</i>		4. DATE OF DEATH <i>April 11 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 2, 1886</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR: Months <i>73</i> Days <i>73</i> Hours <i>73</i> Min. <i>73</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Christian Rauch</i>		14. MOTHER'S MAIDEN NAME <i>Mary Roeh Harkner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Alfred Hamburg</i>		Address <i>1244 Birch Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Posterior myocardial infarction</i> 420.1 DUE TO <i>Coronary thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i> (c) <i>Diabetes mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Summer 1952</i> to <i>4/11 1959</i> , that I last saw the deceased alive on <i>4/11 1959</i> , and that death occurred at <i>2:30 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert J. Levickas</i>		ADDRESS (Street, city or town, state) <i>5305 East Drive Baltimore-27, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Herbert J. Levickas</i>		DATE SIGNED <i>4/11/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/14/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem. Baltimore, Maryland</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amber, Inc. 1328 Sulphur Spring Rd.</i>		24a. REC'D BY REGISTRAR <i>APR 13 '59</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4113

Item 9 Film G241 4-29-59 et

CERTIFICATE OF DEATH

04102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Reisterstown Rd at Valley</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u> c. LENGTH OF STAY IN lb <u>3/23/59 to 4-20-59</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>1716 Yakona Rd</u> b. COUNTY <u>Baltimore County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County, Md</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Williamson</u> Last <u></u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years lost birthday) <u>77</u>
11. BIRTHPLACE (State or foreign country) <u>Mecklenburg County North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Washington Burnette</u>		14. MOTHER'S MAIDEN NAME <u>Mary Solomon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary Rushing-daughter</u>		Address <u>1716 Yakona Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4/18/59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1945</u> to <u>April 20, 1959</u> , that I last saw the deceased alive on <u>April 19, 1959</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>506 E. NORTH AVE</u>		DATE SIGNED <u>4-20-59</u>	
ACTUAL SIGNATURE <u>Jack J. Singer</u>		M.D. <u>BALTIMORE (2) Md.</u>	
PHYSICIAN'S NAME (Type) <u>JACK J. SINGER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/24/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mecklenburg Co., N. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Hgts. Ave.</u>	
24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

Providence Cemetery

Medford, N. J.

James T. Singer

East (Medford) N. J.

Frank J. Singer

East North Ave. Medford, N. J.

Grand St. Medford, N. J.

Medford, N. J.

James T. Singer

James T. Singer

None

No

George Washington (Singer)

George Washington

H. W.

George Washington

W. H. Singer

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

George Washington

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4114

CERTIFICATE OF DEATH

04103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yr23dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2233 St. Lukes Lane - Balto.	
3. NAME OF DECEASED (Type or print) First James Middle Willis Last Willis				4. DATE OF DEATH Month April Day 28 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Unknown Edris A. Willis			
14. MOTHER'S MAIDEN NAME Unknown Elizabeth Ann Ragland				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO. 217-05-5917				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 26, 19 56 to April 28, 19 59 , that I last saw the deceased alive on April 28, 1959 , and that death occurred at 9:50a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				DATE SIGNED 4-28-59			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
22d. LOCATION (City, town, or county) (State) Woodlawn Md.				23. FUNERAL DIRECTOR'S SIGNATURE John L. Henshaw			
24a. REC'D BY REGISTRAR APR 29 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Henshaw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4115

CERTIFICATE OF DEATH

04104

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 32 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NATHANIEL Middle P Last WILLIS		4. DATE OF DEATH Month April Day 9 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 26, 1886
9. AGE (In years lost birthday) yrs. 72		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Novelty Co.	
11. BIRTHPLACE (State or foreign country) Prince George Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Stephen Willis		14. MOTHER'S MAIDEN NAME Minerva Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. --	
17. INFORMANT Clin. Rec., Veterans Adm. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 177X			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 8 , 19 59 , to April 9 , 19 59 , that death occurred on April 9, 1959 , and that death occurred at 11:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH Ft. Howard, Md	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 4/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home		24a. REC'D BY REGISTRAR APR 14 '59	
ADDRESS Holland Funeral Home 1631 Druid Hill Ave. Balto. Md		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or reburial, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3939

CERTIFICATE OF DEATH

04105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1804 Park Ave		d. STREET ADDRESS 1804 Park Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN First JOSEPH Middle WOLF JR. Last		4. DATE OF DEATH Month Apr. Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Stock Clerk		10b. KIND OF BUSINESS OR INDUSTRY Beth Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John J. Wolf		14. MOTHER'S MAIDEN NAME Minnie A. Strube	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 705 10 8163	
17. INFORMANT Lillian C. Wolf		Address 1804 Park Ave 27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 Rt. Temporal Artery Thoma DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 19 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept 1957 to April 12, 1959 , that I last saw the deceased alive on April 4, 1959 , and that death occurred at 9:58 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. EARL PASS		DATE SIGNED 4-14-59	
PHYSICIAN'S NAME (Type) E. EARL PASS, M.D.		ADDRESS (Street, city or town, state) 4001 Wilkens Ave Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/15/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR DATE APR 16 59		24b. REGISTRAR'S SIGNATURE Arthur S. Jones	

Howard H. Hubbard #107 Wilkens Ave.
Bristol 4/15/59 London Park
Baltimore, Md.

Baltimore, Md.

Bristol 4/15/59

London Park

Bristol

4/15/59

London Park

Baltimore, Md.

none

705 10 8163 Lillian C. Wolf, 1804 Park Ave 37

John J. Wolf

Minnie A. Strube

Stock Clerk

Beck Steel Co.

Maryland

US

Male

White

X

Nov. 3, 1901

37

JOHN JOSEPH WOLF JR.

Apr. 12, 1959

1804 Park Ave

1804 Park Ave.

Halethorpe

Halethorpe

Baltimore

Md

Baltimore

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

VS A15 (4)
ISM 10/57

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 583 Goose Neck Rd.</u>		d. STREET ADDRESS <u>Box 583 Goose Neck Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ISABELLE</u> Middle <u>WOLFF</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>6</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George York</u>		14. MOTHER'S MAIDEN NAME <u>Elyabeth ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Geo. E. Wolff</u>		Address <u>Box 583 Goose Neck Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardiovasc. disease</u> DUE TO (c) <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5, 1959</u> , to <u>April 6, 1959</u> , that I last saw the deceased alive on <u>April 6, 1959</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Louis Semenov</u>		DATE SIGNED <u>4/7/59</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		<u>Baltimore 20, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cheney Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connolly</u>		ADDRESS <u>418 Eastern Blvd. (6)</u>	
24a. REC'D BY REGISTRAR <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

4117

CERTIFICATE OF DEATH

04107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Hanover Road		d. STREET ADDRESS Old Hanover Road	
3. NAME OF DECEASED (Type or print) First Cora Middle Estelle Last Yingling		4. DATE OF DEATH Month April Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1881
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Ida E. Allman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Guy W. Yingling, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease 10 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1948 to April 9, 1959 , that I lost sowing the deceased olive on April 9, 1959 , and that death occurred at 11:30 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 4-11-59	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 14/59	22c. NAME OF CEMETERY OR CREMATORY Emory Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Health Officer		15. Signature of County Clerk	
16. Signature of State Health Officer		17. Signature of State Registrar		18. Signature of State Coroner		19. Signature of State Medical Examiner		20. Signature of State Health Officer	
21. Signature of State Registrar		22. Signature of State Coroner		23. Signature of State Medical Examiner		24. Signature of State Health Officer		25. Signature of State Registrar	
26. Signature of State Coroner		27. Signature of State Medical Examiner		28. Signature of State Health Officer		29. Signature of State Registrar		30. Signature of State Coroner	
31. Signature of State Medical Examiner		32. Signature of State Health Officer		33. Signature of State Registrar		34. Signature of State Coroner		35. Signature of State Medical Examiner	
36. Signature of State Health Officer		37. Signature of State Registrar		38. Signature of State Coroner		39. Signature of State Medical Examiner		40. Signature of State Health Officer	
41. Signature of State Registrar		42. Signature of State Coroner		43. Signature of State Medical Examiner		44. Signature of State Health Officer		45. Signature of State Registrar	
46. Signature of State Coroner		47. Signature of State Medical Examiner		48. Signature of State Health Officer		49. Signature of State Registrar		50. Signature of State Coroner	
51. Signature of State Medical Examiner		52. Signature of State Health Officer		53. Signature of State Registrar		54. Signature of State Coroner		55. Signature of State Medical Examiner	
56. Signature of State Health Officer		57. Signature of State Registrar		58. Signature of State Coroner		59. Signature of State Medical Examiner		60. Signature of State Health Officer	
61. Signature of State Registrar		62. Signature of State Coroner		63. Signature of State Medical Examiner		64. Signature of State Health Officer		65. Signature of State Registrar	
66. Signature of State Coroner		67. Signature of State Medical Examiner		68. Signature of State Health Officer		69. Signature of State Registrar		70. Signature of State Coroner	
71. Signature of State Medical Examiner		72. Signature of State Health Officer		73. Signature of State Registrar		74. Signature of State Coroner		75. Signature of State Medical Examiner	
76. Signature of State Health Officer		77. Signature of State Registrar		78. Signature of State Coroner		79. Signature of State Medical Examiner		80. Signature of State Health Officer	
81. Signature of State Registrar		82. Signature of State Coroner		83. Signature of State Medical Examiner		84. Signature of State Health Officer		85. Signature of State Registrar	
86. Signature of State Coroner		87. Signature of State Medical Examiner		88. Signature of State Health Officer		89. Signature of State Registrar		90. Signature of State Coroner	
91. Signature of State Medical Examiner		92. Signature of State Health Officer		93. Signature of State Registrar		94. Signature of State Coroner		95. Signature of State Medical Examiner	
96. Signature of State Health Officer		97. Signature of State Registrar		98. Signature of State Coroner		99. Signature of State Medical Examiner		100. Signature of State Health Officer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4118

CERTIFICATE OF DEATH

04108

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2yr6mth5dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Della Middle Zimmerman Last Zealor				4. DATE OF DEATH Month April Day 23 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1880		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Zimmerman				14. MOTHER'S MAIDEN NAME Margaret Harmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of left kidney 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Degenerative myocardial disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1959 , to April 23, 1959 , that I last saw the deceased alive on April 23, 1959 , and that death occurred at 7:45a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-23-49			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-1959		22c. NAME OF CEMETERY OR CREMATORY Water's Memorial Methodist Cooptown, Harford Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lissaku Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE APR 27 '59	
				24b. REGISTRAR'S SIGNATURE C. King & House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0110

CERTIFICATE OF DEATH

0110

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
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100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

Handwritten signature and text at the bottom of the form.